STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Nursing Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect the resident's (Resident B) right to be free from verbal abuse by CNA 6 for 1 of 3 residents reviewed for abuse. Findings include:During a random observation in the dementia unit dining room on 2/2/26 at 12:10 p.m., CNA 6 was heard yelling If you give me four seconds I will come and get you! at Resident G. During an observation in the dementia unit dining room, with LPN 16 and the assistant to the facility's nurse practitioner present, on 2/2/26 at 12:14 p.m., Resident F repeatedly said I want to lay down. Will you help me? CNA 6 was heard yelling at Resident F, stating If you are going to lay down, then stay down. I can't help you every four seconds. I am not going to give you ice cream, and I am not going to give you cookies. You are going to eat your food!During an interview on 2/2/26 12:17 p.m., CNA 6 indicated she was not yelling at Resident F, she had to talk over her because she did not hear her. She didn't consider her behavior to be abusive. Resident F would eat 40 cookies a day, she just ate cookies and only wanted ice cream. She was not yelling at her; she was yelling across the dining room to get her to eat. She kind of had to get loud, and ignoring Resident F would be considered as abusing her. During an interview on 2/2/26 at 12:32 p.m., LPN 16 indicated he didn't know if he felt what CNA 6 said to Resident F was abuse and didn't hear exactly what she said. It worked better not to yell at the residents and that's what he taught the staff who worked in the dementia unit. He further indicated it was about vocal approach with residents with dementia, he apologized for using the analogy of a stray dog, but he wouldn't approach a stray dog in that manner. It was all about posture and approach, more resistance was usually met when yelling at a resident. If someone talked to him that way, he doubted that he would do what they were asking of him. CNA 6 was normally pretty bubbly and did a good job.Resident F's clinical record was reviewed on 2/3/26 at 9:09 a.m. Diagnoses included vascular dementia, severe, with mood disturbance, psychotic disorder with delusions due to known physiological condition, depression, anxiety, delusional disorders and hallucinations. A 12/2/26 quarterly Minimum Data Set (MDS) assessment indicated she had severe cognitive impairment. She had a current care plan, dated 11/6/25, that indicated she had increased repetitive behaviors. She came in and out of her room requesting cookies. As she ate, she continued to request food and water. Additionally, she stated that she wanted to go back to bed. She wanted something to eat when food was already provided and she was actively eating. She continued to state, Will you get me something to eat? She came out of her room repeatedly requesting food and verbally expressing, I don't feel good, I need something to eat. I want to lay down, I want to go to bed. She exited and re-entered her room [ROOM NUMBER] times. She came out for breakfast and repeatedly stated I want a drink of water, approximately 30 times in one minute. While being assisted with eating, she said I want something to eat, I want to go to bed, I want to lay down on the floor, so I can sleep. She continued to repeat the statements. Interventions included reminiscing with her while sitting at the table (1/21/26), providing (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one-on-one interactions (11/24/25), offering her a movie and television to help calm her (11/7/25) and offering her calming music in her room to help her self-soothe (11/6/25). During an interview on 2/3/26 at 2:10 p.m., CNA 5 indicated Resident F didn't take a moment to listen and that staff needed to use positive words of reinforcement. If Resident F asked for a cookie, staff would sit her down in the dining room to give it to her because CNA 5 was concerned that she may choke in her room. Resident F didn't want to do anything that she did not want to do, including eating, drinking and showering, she reminded Resident F that these activities were in her best interest. She further indicated she witnessed CNA 6 using raised tones with the residents, telling the resident That's enough. CNA 5 felt that staff were to physically care for the residents, not to limit what they could say or do. She had not reported CNA 6 speaking to residents in that manner as there were also other staff who handled Resident F the same way. During an interview on 2/3/26 at 2:26 p.m., RN 17 indicated Resident F could sometimes be difficult. She would come out of her room requesting a cookie or saying that she was hungry. During the evening shift, staff assisted Resident F with eating. If she was seated at the table and staff provided her with something to eat, a drink of water, and a tissue, she would not keep asking for things. RN 17 further indicated that if Resident F had a cookie in her mouth, she would still say that she was hungry. RN 17 described abuse as the intent to harm, scare or not provide a need. She described verbal abuse as talking rude to a resident, being impatient, being loud, or having a change in tone. Staff had to provide kindness to the residents and sometimes that was difficult. Review of CNA 6's employee record information, provided by the Administrator on 2/3/26 at 11:46 a.m., indicated she received education on abuse and neglect on 2/27/25, dementia care on 7/9/25 and 3/4/25, and Resident Rights on 3/3/25. A current facility policy, titled Abuse Prohibition, Reporting, and Investigation, and provided by the Administrator on 2/2/26 at 11:09 a.m., indicated the following: American Senior Communities has established policies and procedures which will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity .Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability 3.1-27(a)(b)