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	02/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to reassess and monitor a resident after a change in condition due to possible aspiration (liquid entering airway) for 1 of 3 residents reviewed for aspiration. (Resident B) This deficient practice resulted in the resident being admitted to the hospital with pneumonia following a subsequent aspiration event.Findings include:An anonymous report submitted to Indiana Department of Health, on 2/16/26 at 12:00 p.m., indicated Resident B choked on his food and clearly aspirated but wasn't sent out to be evaluated. He aspirated again and had to be sent out to the emergency room (ER) for evaluation and was diagnosed with aspiration pneumonia.Resident B's clinical record was reviewed on 2/18/26 at 10:20 a.m. Diagnosis included pneumonia, other disorders of lung and dysphasia (trouble swallowing).Current orders included a one-time chest x-ray (start date 2/12/26), diet orders: no added salt, soft bite- sized. Special instructions: ground meat per request. May have soft cookies and cake (10/24/22). Ipratropium-albuterol solution (breathing treatment) via nebulizer 0.5 milligram (mg)- 3 milligram per 3 milliliters, one nebulizer inhalation every four hours (2/12/26 at 4:00 p.m.) and doxycycline (antibiotic) 100 mg twice a day.A 1/7/26, significant change in status, Minimum Data Set (MDS) assessment indicated Resident B was cognitively impaired, received a mechanically altered diet and required setup or cleanup assistance with eating.A current care plan, initiated on 6/1/22, indicated Resident B had some of his natural teeth. Resident B had a mechanical soft diet related to chewing difficulties. Interventions included monitor for chewing/eating difficulties at meals.A current care plan, dated 9/16/22 and revised on 1/15/26, indicated Resident B was at risk for impaired gas exchange related to pulmonary nodule, history of sinusitis, COVID-19 recovered, history of COVID-19 pneumonia, and newly diagnosed airspace disease. Interventions included assessing vital signs and lung sounds as needed and monitoring oxygen saturation rates as needed/ ordered.A speech Therapy Evaluation and treatment plan, dated 9/16/22, indicated Resident B required a modified diet of thin liquid, soft bite sized foods with mechanical soft/ ground textures.A secure message application, dated 2/12/26 at 1:09 p.m., indicated staff members informed the Nurse Practitioner (NP) that Resident B aspirated on his lunch, he kept coughing up phlegm and had audible congestion at bedside. Current vital signs included oxygen saturation in the 80's while on two liters of oxygen, blood pressure was 96/58 millimeters of mercury (mmHg) (a normal blood pressure reading is 120/80) and temperature was 98.2 degrees Fahrenheit. The NP ordered breathing every four hours for two days and a stat (immediate) chest x-ray.A progress note, dated 2/12/26 at 2:10 p.m., indicated a new order for a stat chest x-ray was received related to possible aspiration.A progress note, dated 2/12/26 at 2:39 p.m., indicated a mobile chest x-ray was completed at that time.A chest x-ray imagine report, dated 2/12/26 at 2:48 p.m., indicated Resident B's lungs showed patchy modest bilateral airspace disease. Pneumonia should be considered in the appropriate clinical setting. Recommend a follow-up examination to confirm resolution of findings.A progress note, dated 2/12/26 at 4:20 p.m., recorded as (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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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a late entry on 2/16/26 at 9:21 a.m., indicated Resident B's chest x-ray results indicated patchy modest bilateral airspace disease. The NP was notified.The clinical record lacked documentation that Resident B was reassessed, and vital signs were completed between 2/12/26 at 1:09 p.m. and the NP's note on 2/13/26 at 12:24 p.m.A Physician Progress note, dated 2/13/26 at 12:24 p.m., recorded as a late entry on 2/16/26 at 12:24 p.m., indicated Resident B experienced an episode of hypoxemia (low blood oxygen) following a choking incident during a meal. Currently, patient was in no obvious respiratory distress, and lung examination revealed clear breath sounds. Plan: Administer breathing treatment every four hours for the next 24 hours to assist with bronchodilation (opening airways) and improve oxygenation. Monitor oxygen saturation levels closely. Reassess respiratory status periodically to ensure no further episodes of hypoxemia occur. Chest x-ray findings were suggestive of pneumonia, likely secondary to aspiration during the choking episode. Plan: Initiate doxycycline 100 mg orally twice a day for seven days to treat suspected bacterial infection. Monitor for signs of improvement or worsening, such as fever, increased cough, or dyspnea. Follow up chest x-ray may be considered if symptoms persist or worsen.A February 2026 Medication Administration Record (MAR) indicated doxycycline was not administered on 2/13/26 at 8:00 p.m. or 2/14/26 at 8:00 a.m. On 2/13/26 at 9:13 p.m., staff documentation indicated doxycycline was not available as it had not arrived. On 2/14/26 the MAR did not indicate that Resident B's doxycycline was administered.The clinical record lacked documentation that the doxycycline was administered when delivered to the facility.The clinical record lacked documentation that Resident B was assessed, and vital signs were completed between the NP's documentation on 2/13/26 at 12:24 p.m. and Resident B's decline in condition on 2/14/26 at 1:50 p.m. A Situation, Background, Assessment and Recommendation (SBAR) event report, dated 2/14/26 at 1:50 p.m., indicated Resident B had decreased oxygen saturation, increased congestion, and resident representative requested for him to go to the emergency room (ER) for evaluation and treatment. Resident B's vital signs included a temperature of 98.1 degrees Fahrenheit, heart rate was 113, blood pressure was 105/51 mmHg, and respirations were 12. He was currently on two liters of oxygen via nasal cannula with an oxygen saturation of 80%. Assessment included he had increased congestion and decreased oxygen saturation and was on antibiotics for pneumonia. Orders included sending Resident B to the Hospital for evaluation and treatment.A progress note, dated 2/14/26 at 6:25 p.m., indicated Resident B would be transferred to another hospital with a diagnosis of aspiration pneumonia.A hospital progress note, dated 2/15/26, indicated Resident B was seen for worsening difficulty breathing and lethargy. Resident B was reported to have received treatment for aspiration pneumonia, after an aspiration event two days prior. He was found on CPAP (non-surgical treatment delivering oxygen through a mask to keep a person's airways open), tachypneic (rapid, shallow breathing) with coarse breath sounds in the bases bilaterally on his lung examination on arrival to the Emergency Department. Resident B received some doxycycline shortly prior to arrival and Emergency Medical Staff (EMS) were called due to worsening difficulty breathing. Prior to his arrival, Resident B was hypoxic (body tissues don't receive adequate oxygenated blood causing damage to organs) and tachypneic (high heart rate). He had a headache and a nonproductive cough. His white blood cell count was mildly elevated at 11.2 (indicating infection response). Hospitalist Impression: Resident B who had a prior history of aspiration with residual debility presented with a history of aspiration. Chest x-ray was notable for new patchy interstitial and alveolar opacity particularly in the left chest suggestive of pneumonitis (lung tissue inflammation). Acute hypoxic respiratory failure requiring two liters of oxygen via nasal cannula. Resident B was not on oxygen at his baseline. A hospital progress note, dated 2/17/26 at 2:06 a.m., indicated Resident B continued to have very coarse lung sound bilaterally.During an interview, on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2/19/26 at 10:43 a.m., LPN 4 indicated Resident B sounded like he had a lot of mucous and congested when staff members brought Resident B back to his room. She assessed Resident B and noted that his oxygen saturation was low. She placed oxygen on Resident B at two liters per minute. She used a secure messaging application to notify the NP of Resident B's condition. She received the orders for a stat chest x-ray and breathing treatments.On 2/19/26 at 10:50 a.m., CNA 5 indicated during the lunch meal Resident B sounded like he was gurgling. Resident B tried to drink but couldn't keep anything down. Staff propelled resident back to his room so the nurse could assess him.On 2/19/26 at 10:55 a.m., the Culinary Manager indicated Resident B had coughed after drinking. A nurse was present in the dining room who went over and checked on him. Resident B had a wet-like cough.On 2/19/26 at 11:20 a.m., the Administrator indicated Resident B started coughing during his lunch meal. He wasn't choking, just coughing.On 2/19/26 at 2:15 p.m., the NP indicated she was notified through the secure messaging application around 1:00 p.m. on 2/12/26 regarding Resident B's condition. It appeared Resident B had aspirated during lunch. His oxygen saturation had dropped, and staff placed him on oxygen at two liters per minute. She ordered breathing treatments every four hours and a stat chest x-ray. She did not see his chest x-ray results until she came into the facility on 2/13/26, the following day. She spoke with staff when she arrived to the facility and Resident B was doing better. She assessed Resident B and listened to his lung sounds. She did not check any of his vital signs. He was still wearing oxygen but was not in any distress. After looking at Resident B's chest x-ray results, she wasn't super convinced he had pneumonia, but placed him on doxycycline just in case. She did not speak with the nurse about watching Resident B's oxygen saturation or re-assessing him as he had a change in condition as she had left the facility without speaking with staff members. She assumed it was part of the facility's protocol. There was no further communication from staff after the initial message was received. The next communication notified her of Resident B needing to be sent to the hospital following a change in his condition after a second episode of possible aspiration on 2/14/26. Her reading the triage note, Resident B was very congested and his oxygen saturation was in the 80's while on two liters of oxygen. He had difficulty eating lunch and seemed to aspirate again. He was not in any distress the day prior when she saw him.On 2/19/26 at 4:40 p.m., LPN 9 indicated she noticed Resident B was drooling, having trouble chewing, swallowing, and started coughing during the lunch meal on 2/14/26. She knew Resident B was already on antibiotics as he had already aspirated previously. Her and LPN 4 decided to take Resident B back to his room to be assessed. His oxygen saturation was in the 80's. They called Resident B's representative, who wanted him sent out to the ER for evaluation. LPN 9 validated that Resident B did not have any vitals documented under the vitals tab between 2/9/26 and 2/18/26. There were no notes to indicate Resident B was assessed between the two separate alleged aspirations, on 2/12/26 and 2/14/26, besides the NP's progress note on 2/13/26.On 2/19/26 at 4:55 p.m., LPN 4 indicated Resident B was sent out to the ER on [DATE]. There was no progress note documented in the Electronic Medical Record (EMR). If staff charted on the incident, it would have been listed under the progress notes tab in the EMR. If an issue arose with any resident it would be documented under their progress notes. After a breathing treatment, an assessment was performed and their vitals were to be documented in the MAR along with the breathing treatment orders.On 2/19/26 at 5:08 p.m., LPN 10 indicated she worked 2/13/26. Resident B was fine during her shift. Resident B had breathing treatments and a chest x-ray the day prior. Resident B did not receive any doxycycline during her shift, as the medication hadn't arrived from the pharmacy. She did not do a full assessment of the resident; she only listened to his lungs. No other vitals were taken. The situation didn't warrant her to do a full set of vitals, as Resident B was not showing any signs of (continued on next page)

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