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	03/24/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a nurse obtained a physician's order prior to inserting and anchoring a urinary catheter for 1 of 3 residents reviewed for hospitalizations. (Resident B)Findings include:During an interview on 3/23/26 at 3:20 p.m., Resident B indicated he was in the hospital a couple weeks ago, he did not remember what his symptoms were at the time, but the symptoms came on suddenly. He felt that the facility acted promptly and he had no concerns. During an interview on 3/24/26 at 8:50 a.m. RN 19 indicated he arrived at work on 3/1/26 at 6:00 p.m. but did not take over the hall until 10:00 p.m. During report, he was told that Resident B's had blood in his urine that started earlier and LPN 13 had catheterized him. RN 19 checked on Resident B and noted the resident had an anchored urinary catheter and was not actively bleeding and there was no blood in the urinary drainage bag. Lab staff arrived at approximately 4:00 a.m. RN 19 obtained the urine sample and deflated the balloon, and removed the catheter because it was not needed. Resident B began bleeding from his penis. Attempts were made to stop the bleeding, but it was profuse. RN 19 called the on-call NP and sent Resident B to the hospital. During an interview on 3/24/26 at 9:07 a.m. the Director of Nursing (DON) indicated, with the Administrator present, that she started an IV on Resident B on 3/1/26. His blood pressure was low, and he was not acting like himself. He was awake and talking to her. Stat (immediate) labs and a urinalysis were ordered. Bleeding was noted after the in and out catheterization. He had a history of hematuria (blood in the urine). They would not normally anchor a Foley catheter to get a urinalysis.During an interview on 3/24/26 at 12:00 p.m., RN 21 indicated that if she received an order for a urinalysis, she would collect a clean-catch specimen (in a cup) if the resident was able. If the order specified, she would do a straight catheterization (in and out). She would not anchor a Foley catheter for an urinalysis and an order was needed to insert a Foley catheter. A Foley catheter was not temporary, and a diagnosis was needed to anchor one.During an interview on 3/24/26 at 12:10 p.m. LPN 3 indicated that she worked with a QMA on 3/1/26. The QMA reported that Resident B did not take his medication, he tried to eat breakfast with his remote, he had blood in his brief and his scrotum was red. The QMA obtained vital signs, his blood pressure was low, and he had a low-grade temperature. LPN 3 check on Resident B, she had no correlation with him or had ever met him before. He did not smile, he had opened eyes and looked totally drained. The DON was in the facility and started the IV. She did not attempt to obtain the urinalysis as she knew the lab staff did not come until the next day and she was told to wait for second shift to obtain the urine specimen to make sure it was viable. The NP did not send Resident B out and gave orders to treat him in the facility. She would not anchor a Foley to obtain urine specimen and a order was needed prior to inserting a Foley catheter. During an interview with the Administrator and the DON, on 3/24/26 at 3:52 p.m., the Administrator indicated that an incontinent resident would normally be straight catheterized for a urine specimen. The DON indicated that the nurses needed a physician's order to anchor a Foley catheter.During an interview with LPN 13, on 3/24/26 at 4:00 p.m., she indicated, on the day in question, Resident B had not been voiding. He was normally incontinent but the aides reported that he had been dry. She believed he was probably dehydrated. She inserted the smallest catheter available and did not get any urine return. She decided (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to inflate the 10 cc balloon in the catheter rather than attempting to catheterize him again. He was in pain, as he did not normally have a catheter. She further indicated there was not a physician's order for the Foley catheter and she should have obtained an order prior to inserting a Foley.During an interview on 3/24/26 at 2:37 p.m. the Senior Regional Director of Clinical Services indicated they did not have a policy related to physicians' orders.Resident B's clinical record was reviewed on 3/23/26 at 9:35 a.m. Diagnoses included essential (primary) hypertension, iron deficiency anemia, unspecified sequelae of cerebral infarction, chronic pain syndrome, hypokalemia, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, urinary tract infection, and bandemia.A 1/21/26 quarterly Minimum Data Set (MDS) indicated he had moderate cognitive impairment. He was always incontinent of bowel and bladder.On 3/1/26 at 10:47 a.m., the triage note from the messaging system indicated an on-call Nurse Practitioner (NP) was notified that Resident B had a possible urinary tract infection (UTI). He had blood in his urine, burning with urination, and altered mental status. Orders received included urinalysis with culture and sensitivity.A late-entry nurse's note, dated 3/1/26 at 3:30 p.m., indicated Resident B had a change in condition, including blood in his urine and blood pressure lower than his baseline. The on-call provider was notified. New orders were received for intravenous (IV) fluids and labs. A peripheral IV was inserted into the right forearm.On 3/1/26 at 7:56 p.m., the triage note from the messaging system indicated the on-call NP was notified through the messaging system. The facility nurse indicated that Resident B had a change in condition that morning and had blood in his urine. An order was received for urinalysis. Resident B indicated that he wanted to go to the hospital. The facility nurse indicated that Resident B had a UTI or was possibly septic (blood infection), as he had been in past. The nurse planned to do a urinalysis with culture and sensitivity in the morning and requested antibiotic therapy for a UTI. The facility nurse reported that the urine sample had not yet been collected and was in progress. The on-call NP gave orders for antibiotics but requested the urine sample be collected prior to administration.A nurse's note dated 3/1/26 at 11:17 p.m. indicated the resident was alert and provided eye contact. He refused to eat and had small amount of emesis (vomiting) and phlegm. He grabbed at staff during assessment. A urine sample was attempted but unable to be obtained. He urinated once and passed a blood clot.On 3/2/26 at 4:23 a.m., the triage note from the messaging system indicated the on-call NP was notified that the resident was bleeding profusely from his urethra when his in and out catheter was removed and requested that he be sent to the emergency roomA nurse's note dated 3/2/26 at 9:04 a.m. indicated a nurse at the local hospital reported Resident B was being admitted to the critical care unit for diagnoses of septic shock, UTI, and urosepsis (urinary infection spread to bloodstream). A 16 French catheter had been inserted at the hospital. He had a fever of 103.1 degrees Fahrenheit (F) which was being managed with medications and the fever had decreased to 101.3 F.This citation relates to Intake 2796209.410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(1)