| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155200 | A. Building<br>B. Wing | 09/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| University Nursing Center | 1564 S University Blvd<br>Upland, IN 46989 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>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<br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 concerns with CNA 8.A current policy, titled Abuse Prohibition, Reporting and Investigation, provided by the Administrator, on 9/9/25 at 12:24 p.m., indicated the following: .Neglect. Failure to provide goods and services to a resident(s) necessary to avoid physical harm, pain, mental anguish, or emotional distress.This citation relates to Intake 2611663. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for a resident with physical limitations by ensuring the resident's call light was within reach for 1 of 1 residents reviewed for resident rights. (Resident 2)Findings include:Resident 2's clinical record was reviewed on 9/5/35 at 10:22 a.m. Diagnoses included hypertensive heart disease with heart failure, anemia, asthma, age-related osteoporosis, macular degeneration, overactive ladder, cognitive communication deficit, and unsteadiness on feet.Current physician's orders included activity level - up with mechanical lift and two person assist, wheelchair for mobility on unit, bunny boots to be worn in bed at all times and heels to be floated every shift, document in milliliters (mL) all fluids taken with medications every shift, offer additional 240 mL fluids every shift, and head of bed elevated while in bed to alleviate shortness of breath while lying flat related to diagnosis of asthma.A significant change Minimum Data Set (MDS) assessment, dated 8/8/25, indicated Resident 2 was severely cognitively impaired, dependent for all transfers, and was incontinent of both bowel and bladder. During an observation on 9/3/25 at 11:29 a.m., Resident 2 was seated in her room in a wheelchair with a blanket over her legs. The resident's call light was on the floor behind the right head of the bed. On 9/4/25 at 8:58 a.m., Resident 2 was seated in a wheelchair, asleep, next to her bed. The resident's call light was lying on the floor behind her bed. On 9/4/25 at 9:59 a.m., the resident was asleep in bed. A bedside table, approximately three to four feet from her bed, contained an empty cup of water and a fork. The resident's call light was on the floor behind her bed and a clear plastic cup was lying on the left side of her bed, upside down on the floor.On 9/8/25 at 3:34 p.m., Resident 2 was asleep in bed. The call light was lying on the floor behind the resident's right head of the bed. On 9/9/25 at 8:48 a.m., Resident 2 was asleep in bed. The resident's breakfast tray was on the bedside table next to her bed. The silverware was still wrapped in a napkin and breakfast had not been eaten. There was a cup of juice on the breakfast tray, untouched. The resident's call light was on the floor at the right head of the bed.During an interview with CNA 17 on 9/9/25 at 8:57 a.m., he indicated he did not know if the resident required assistance to eat and/or drink. CNA 17 entered Resident 2's room and picked up the call light from the floor at the head of the bed and attached it to the resident's blanket. He indicated the call light should be within reach for Resident 2.During an interview with LPN 7 on 9/9/25 at 10:23 a.m., she indicated she did not know if the resident was able to use the call light. A current care plan, revised on 8/4/25, indicated the resident was at risk for falls and required assistance or supervision for mobility, transfer, and ambulation. Interventions included keeping personal items in reach, call light in reach, and non-skid footwear.During an interview, on 9/9/25 at 8:57 a.m., the DON indicated she would locate a policy for call light access. No further information was provided prior to survey exit. 3.1-3(v)(1) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents prescribed antipsychotic medications received appropriate Gradual Dose Reductions (GDR) or had individualized indication for continued use of antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 10)Findings include:Resident 10's clinical record was reviewed on [DATE] at 2:48 p.m. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy body dementia (a progressive degenerative brain disorder), chronic diastolic heart failure, anxiety disorder, major depressive disorder, and senile degeneration of the brain. Current physician's orders included venlafaxine extended release 150 milligrams (mg) once a day for depression, hydrocodone-acetaminophen 5-325 every eight hours for pain, quetiapine (antipsychotic) 75 mg three times a day, trazodone 25 mg at bedtime for insomnia, and alprazolam 0.5 mg three times a day for anxiety.A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident 10 did not exhibit delusions, hallucinations, or behaviors.A quarterly MDS assessment, dated [DATE], indicated Resident 10 did not exhibit delusions, hallucinations, or behaviors.A quarterly MDS assessment, dated [DATE], indicated Resident 10 did not exhibit delusions, hallucinations, or behaviors. A quarterly MDS assessment, dated [DATE], indicated Resident 10 did not exhibit delusions, hallucinations, or behaviors. A significant change MDS assessment, dated [DATE], indicated Resident 10 was moderately cognitively impaired, exhibited no hallucinations, delusions, or behaviors, required supervision for eating and oral hygiene, substantial assistance for toileting, was dependent for showering/bathing, and needed substantial assistance for toileting hygiene.A current care plan, initiated [DATE], indicated the resident was noted to have visual hallucinations as evidenced by seeing things that were not present, seeing people in his room that were not there, and thoughts that others were trying to harm him. He had a diagnosis of Lewy body dementia and received an antipsychotic. Interventions included approaching the resident with preferred staff members ([DATE]) and providing the resident with reassurance ([DATE]).A current care plan, initiated [DATE], indicated Resident 10 exhibited signs and symptoms of yelling he had fallen out of bed. The resident yelled for help but when staff went to assist, he was unable to say what he needed. When staff left the room, the resident would start yelling for help again. He had a diagnosis of dementia. Interventions included making sure the resident had no unmet needs, allowing him to verbalize his feelings and provide validation when able, offer repositioning for comfort, and help him get his feet back into the bed when needed. A current care plan, initiated [DATE], indicated Resident 10 was at the front door, stating he wanted to leave the facility. The environment was quiet, and he grabbed a binder from a table near the door and attempted to hit the front door with the binder. He had a diagnosis of dementia. Interventions included allowing the resident personal space and time to calm down as needed and treat the resident for infection as indicated. A current care plan, initiated [DATE], indicated Resident 10 was visiting with family, got upset with his daughter, and attempted to hit his daughter. He told family to shut up and his daughter needed to listen to him. The daughter was unable to redirect her father. Interventions included reapproaching the resident with a preferred staff member, giving the resident time to calm down, and redirecting the resident away from family members if he was upset. A current care plan, initiated [DATE], indicated Resident 10 was yelling and cursing at staff while they attempted to provide care and medications. He stated he wanted to leave the room and see his wife. The resident had diagnoses of Lewy body dementia and anxiety. Interventions included allowing the resident to calm down before providing care and offering to have him visit his wife after supper when possible. A current care plan, initiated on [DATE], indicated Resident 10 had a history of displaying signs and symptoms of mood distress as evidenced by finding little interest or pleasure in doing things. Interventions included identifying relationships the resident<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | could benefit from, acknowledging to the resident his current situation was difficult, encouraging the resident to verbalize his feelings, concerns, fears, help clarify misconceptions, and establishing a trusting relationship with the resident. A current care plan, initiated [DATE], indicated Resident 10 was noted with restlessness, shortness of breath, anxiousness, irritability, tearfulness, and repetitive statements. He would talk nonsensically, make repetitive statements, and would become nauseated as anxiety increased. He had a diagnosis of anxiety disorder and received medication for anxiety. Interventions included assisting the resident to bed if he desired, offering anti-nausea medication as ordered when needed, offering magazines about birds or wildlife to read, encourage the resident to talk about his wife and daughters, encourage the resident to rest, reapproach the resident later, give him personal space as needed, and provide a calm environment as needed.A current care plan, initiated [DATE], indicated Resident 10 was noted to have tearfulness, restlessness, irritability, a somber mood, sad facial expressions and feelings of sadness. He had a diagnosis of major depressive disorder and received an antidepressant. Interventions included helping him to lay down and rest if desired, taking the resident outside in good weather, providing reassurance, and encouraging the resident to verbalize his concerns and worries. A behavior communication note, dated [DATE] at 1:56 p.m., indicated Resident 10 was very anxious and made multiple statements of confusion and anxiety, to the point he vomited. His daughter was visiting and took him for a walk because he was upset because he could not leave the facility. He continued to be anxious and became nauseated. Anti-nausea medication was administered, and Resident 10 was assisted into bed to rest. He eventually calmed but continued to be tearful. A behavior communication note, dated [DATE] at 5:30 p.m., indicated Resident 10 was in a somber, sad mood and refused to eat dinner or drink fluids. Staff attempted to feed him, but he still refused. Staff offered anti-nausea medication, which he refused. There were no signs of nausea or anxiousness noted. The resident was assisted to bed and by bedtime, he was in a better mood.A behavior communication note, dated [DATE] at 11:30 a.m., indicated Resident 10 refused to eat lunch, complained of nausea, headache, and dizziness, and did not feel well. He was very anxious and stated more than once he needed medication(s). Resident 10 was removed from the dining room to a quieter environment. Anti-nausea medication was administered and after an hour or so, he was able to calm himself. Interventions were effective.A behavior communication note dated [DATE] at 7:00 a.m., indicated Resident 10 was yelling out, stating repeatedly he had fallen out of bed. He did not fall out of bed, but his feet were hanging out of bed. Staff would reposition and reassure the resident as needed. Interventions were somewhat effective.A progress note, dated [DATE] at 10:15 a.m., indicated Resident 10 had an infection which could be contributing to his increased confusion. A behavior communication note, dated [DATE] at 8:00 a.m., indicated the resident was yelling for help but could not identify what he needed. Staff spoke calmly to the resident and reassured him all was well. He was assisted into his wheelchair as a distraction. Interventions were somewhat effective. Resident 10 continued to have moments of confusion with anxiety throughout the rest of the shift.A progress note, dated [DATE] at 1:06 p.m., indicated Resident 10 was upset and repetitively asking for help. He did not know what he needed, was made comfortable, refused breakfast, was given anti-nausea medication, and reapproached later with morning medications.A psychiatric nurse practitioner's note, dated [DATE] at 7:32 p.m., indicated Resident 10's current cognitive status was consistent with dementia. The resident reported confusion and disorientation, such as believing he had been married to his wife for 82 years, which was indicative of the behavioral disturbances associated with dementia. The plan was to monitor Resident 10's cognitive status and behavioral disturbances. Resident 10 reported feeling not like himself and experienced strange sensations behind his eyes, which could also be symptoms related to dementia.A behavior communication note, dated [DATE] at 9:00 a.m., indicated Resident 10 called for the nurse multiple times but was unable to state what he needed. He became increasingly anxious to the point of nausea and vomiting. Anti-nausea medication was administered and effective for a short while. Resident 10 was turned and repositioned, incontinent care was provided, and staff reassured<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the resident multiple times. Interventions were not effective. A behavior communication note, dated [DATE] at 9:00 a.m., indicated the resident was restless and anxious with behaviors of calling out for the nurse continuously, unable to state his needs. He became quite loud and adamant. He was reassured by staff that all cares would be provided, but he would have to be patient until staff were available to assist him with getting out of bed. Resident 10's blinds were opened, and he was encouraged to watch the birds at the feeder outside his room. Staff returned shortly to assist Resident 10 out of bed. He was placed in his wheelchair and sat in the hallway for closer monitoring and frequent reassurance. Interventions were somewhat effective, and behavior improved but Resident 10 continued to be confused and was quick to become agitated. A behavior communications note, dated [DATE] at 8:30 a.m., indicated Resident 10 was yelling out for (name), stating he needed to see his wife. He became very agitated and hot which caused nausea and vomiting. The room temperature was lowered, and he was given a cool washcloth. Anti-nausea medication was administered. Interventions were effective.A progress note, dated [DATE] at 7:46 a.m., indicated Resident 10 refused to take his opioid pain medication. He insisted that the medication made him sick to his stomach. He was told the medication was for pain but when the nurse tried to put the medication in his mouth, he would push out the pill with his tongue. The conversation was repeated more than once, with the resident refusing the medication and pushing the pill out of his mouth with his tongue. His wishes were eventually honored after more than one attempt to get him to take the medication. A psychiatric nurse practitioner's note, dated [DATE] at 6:16 a.m., indicated Resident 10 was being seen for psychotherapy services for the treatment, monitoring, medication monitoring, and support of symptoms related to dementia, anxiety, major depressive disorder, and insomnia. The resident presented with worry and the therapist and resident discussed his current emotions. He denied any acute distress. The resident noted that he was worried about his roommate. During the session, the therapist and Resident 10 discussed his family and their travels. Resident 10 was pleasant and cooperative, reported feeling fine and denied issues with sleep, depression, anxiety, and auditory or visual hallucinations. A progress note, dated [DATE] at 2:00 p.m., indicated Resident 10 was at the front door of the facility. The environment was busy. The resident was noted to have increased confusion and agitation. He was yelling at his daughters and said he needed to get out of the facility and go home. He was aggressive with staff who attempted to assist/calm him. Resident 10 was given time to calm down before reapproaching him, he was offered the chance to go to the courtyard and offered something to eat or drink. Interventions were ineffective but Resident 10's daughters were able to calm and redirect him. A social services note, dated [DATE] at 10:07 a.m., indicated Resident 10 was experiencing increased urinary urgency and burning while urinating. Urine was to be tested to rule out infection. Resident 10 had diagnoses of anxiety and dementia which could cause increased behaviors when infection was present. A behavior communication note, dated [DATE] at 4:49 a.m., indicated the resident was defiant and became aggressive during incontinent care. He swore at staff, grabbed and pinched them, and was swinging at them. He refused his medications. Two hours later, he readily took his medications. A psychiatric nurse practitioner's note, dated [DATE] at 8:14 a.m., indicated Resident 10 was seen for dementia, anxiety, major depressive disorder, and insomnia. The resident's psychiatric diagnoses were chronic and fluctuated in severity. Resident 10's speech was mumbled and difficult to understand at times. He was unable to answer most questions appropriately. He experienced intermittent non-distressing delusions, though none had been noted recently. No suicidal or homicidal ideations were noted. No depression or anxiety was observed during the session. Resident 10 denied auditory or visual hallucinations. He was diagnosed with severe cognitive impairment and mild depression. Staff did not report recent aggression, agitation, or combativeness with care (though he had episodes of combativeness in the past.) No new or worsening behaviors were reported. The resident was compliant with medications. Resident 10's current medication regimen included venlafaxine 150 mg daily, quetiapine 75 mg three times a day, and alprazolam 0.5 mg three times a day. No anxiety was noted during the evaluation. Medication<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | regimen was to continue, and a follow-up appointment was scheduled. Medications were reviewed for possible gradual dose reduction (GDR) of psychotropics. Any reduction in regimen was likely to risk decompensation and was not recommended. The benefits outweighed the risks and there was no clinical indication for GDR of psychiatric medications.A [DATE] pharmacy recommendation indicated a review was due for quetiapine 75 mg three times a day for neurocognitive disorder with Lewy bodies/delusional disorder. Targeted behaviors included hallucinations and seeing things that were not present. On [DATE], Resident 10 presented with anxiety. On [DATE] the resident was sad and refused meal and fluids. On [DATE], the resident refused meal and had anxiety. Date of the last attempted GDR was [DATE] which was contraindicated by the provider. On [DATE], the provider determined a reduction in the medication could increase psychiatric instability. A [DATE] pharmacy recommendation indicated a review was due for quetiapine 75 mg three times a day for Lewy body dementia/delusions. Targeted behavior was delusional thinking. The resident had recent behaviors (unspecified dates and examples). Last attempted GDR was [DATE] and was declined by the provider. On [DATE], the provider determined a reduction in the medication would be a detriment to the resident's mental health. A 4/14 25 pharmacy recommendation indicated a review was due for quetiapine 75 mg three times a day for delusional disorder. Targeted behavior was delusional thinking. There were no noted recent behaviors. Last attempted GDR was [DATE] and was declined by the provider. On [DATE], the provider determined a reduction in the medication was contraindicated because the resident was seeing his (deceased ) wife.The clinical record lacked documentation of Resident 10 seeing his (deceased ) wife.A [DATE] pharmacy recommendation indicated a review was due for quetiapine 75 mg three times a day for delusional disorder. Targeted behaviors were delusional thinking and hallucinations. There were no noted recent behaviors. Last attempted GDR was [DATE] and was declined by the provider. On [DATE], the provider determined a reduction in the medication was contraindicated because the family declined (all) GDRs and the resident exhibited some behaviors (unspecified dates and examples). The clinical record lacked documentation of Resident 10 exhibiting signs or symptoms of delusions and/or hallucinations.A [DATE] pharmacy recommendation indicated a review was due for quetiapine 75 mg three times a day for delusional disorder. Targeted behaviors were delusional thinking and restlessness. There were no noted recent behaviors. Last attempted GDR was [DATE] and was declined by the provider. On [DATE], the provider determined a reduction in the medication was contraindicated because Resident 10's family refused GDRs, and the resident was stable on current medication regimen.During an observation on [DATE] at 2:23 p.m., Resident 10 was sitting upright in his bed eating a snack. The television was playing but he was not watching. Resident 10's interest remained on the snack.During an interview with LPN 12 on [DATE] at 2:27 p.m., she indicated Resident 10 exhibited behaviors like looking for his car, car keys, or his truck. He was never aggressive. It was his anxiety which caused his distress. She thought his expressions of anxiety had improved. He was taking the quetiapine for his anxiety and behaviors. Resident 10's daughter wanted to be consulted before any GDRs.During an observation on [DATE] at 9:17 a.m., Resident 10 was cooperative with staff during a dressing change. He was able to answer questions appropriately. During an observation on [DATE] at 3:30 p.m., Resident 10 was sleeping in his bed. During an interview with psychiatric Nurse Practitioner (NP) 13 on [DATE] at 4:28 p.m., she indicated Resident 10's family had been consulted on numerous occasions and were not agreeable to GDRs. NP 13 had provided black box warning information to the family. NP 13 did not have access to pertinent information at the time of the interview, but did know Resident 10 exhibited anxiety and restlessness. She did not know much about Resident 10's mental health history and had picked him up as a patient when she hired on with the facility at the beginning of 2025. She had seen Resident 10 during periods of depression and anxiety. Resident 10 had expressed anxiety about his family and how they were doing or that he had not seen them in a while. A current facility policy, titled Medication Stop Orders, provided by the Administrator on [DATE] at 8:49 a.m., indicated the following: .3. (The) facility should ensure that all medications which have run the normal course of<br>(continued on next page) |

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| University Nursing Center | 1564 S University Blvd<br>Upland, IN 46989 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | therapy or are no longer necessary to treat the resident's condition are discontinued. A current facility policy, titled Medication Regimen Reviews and Pharmacy Recommendations, provided by the Administrator on [DATE] at 8:49 a.m., indicated the following: .It is the policy of (name of facility) that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed pharmacist, attending physician, medical director, and director of nursing.9.2.1 If the attending physician/prescriber has decided to make no changes in the medication, the attending physician should document the rationale in the resident's' health record. 3.1-48(a)(4)3.1-48(b)(2) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observation, interview, and record review, the facility failed to ensure a dependent resident had access to drinking water or other fluids for 1 of 1 residents reviewed for hydration. (Resident 2)Findings include:During an observation on 9/3/25 at 11:29 a.m., Resident 2 was seated in her wheelchair with a blanket over her legs. Across the room, near the other bed, there were two bedside tables. One had a bottle of syrup and a cup of water lying on it. During an observation on 9/4/25 at 9:59 a.m., the resident was asleep in bed. A bedside table, approximately three to four feet from her bed, contained an empty cup of water and a fork. The resident's call light was on the floor behind her bed and a clear plastic cup was lying on the left side of her bed, upside down on the floor.Resident 2's clinical record was reviewed on 9/5/35 at 10:22 a.m. Diagnoses included hypertensive heart disease with heart failure, anemia, asthma, age-related osteoporosis, macular degeneration, overactive ladder, cognitive communication deficit, and unsteadiness on feet.Current physician's orders included activity level - up with mechanical lift and two person assist, wheelchair for mobility on unit, bunny boots to be worn in bed at all times and heels to be floated every shift, document in milliliters (mL) all fluids taken with medications every shift, offer additional 240 mL fluids every shift, and head of bed elevated while in bed to alleviate shortness of breath while lying flat related to diagnosis of asthma.An 8/8/25 significant change Minimum Data Set (MDS) assessment indicated Resident 2 was severely cognitively impaired, did not exhibit delusions, hallucinations, or behaviors, was dependent for all transfers, and was incontinent of both bowel and bladder. The significant change MDS assessment was triggered because the resident had a significant weight loss. A current care plan, revised on 7/22/25, indicated Resident 2 was at risk for fluid imbalance due to a diagnosis of overactive bladder and medications used for overactive bladder. Interventions included provide an extra 240 mL of fluids every shift, encourage fluids, document and notify the medical director of signs and symptoms of fluid volume deficit (dry mucous membranes, thirst, weight loss, decreased blood pressure, weak/rapid pulse, change in mental status, decreased urine output, abnormal labs, poor skin turgor), and record intake of fluids. A current care plan, revised on 7/22/25, indicated Resident 2 required assistance and/or monitoring of am/pm care, nutrition, hydration, and elimination. Interventions included record intake of night shift fluids, record lunch intake percentage and fluid consumption, record dinner intake percentage and fluid consumption, and record breakfast intake percentage and fluid consumption.A current care plan, revised on 8/4/25, indicated the resident was at risk for falls and required assistance or supervision for mobility, transfer, and ambulation. Interventions included keeping personal items in reach, call light in reach, and non-skid footwear.During an observation on 9/8/25 at 3:34 p.m., Resident 2 was asleep in bed. There were no drinks on the bedside table. During an interview with CNA 17 on 9/9/25 at 8:57 a.m., he indicated he did not know if the resident required assistance to eat and/or drink. During an interview with RN 18 on 9/9/25 at 9:04 a.m., she indicated Resident 2 might require some coaxing at first, but could feed herself and drink liquids without assistance.During an interview with LPN 7 on 9/9/25 at 10:23 a.m., she indicated Resident 2 was able to drink fluids without assistance. The CNAs passed water to the residents every shift. A current facility policy, titled Hydration Management, provided by the Administrator on 9/8/25 at 2:47 p.m., indicated the following: .It is the policy of (company) to ensure that each resident is offered sufficient fluid intake to maintain proper hydration.1. Resident hydration status will be assessed upon admission or readmission, with significant change and quarterly utilizing the IDT (interdisciplinary team) hydration review. 2. Any resident with identified risk factors will be assessed by the IDT and documentation will be placed in the electronic medical record (EMR) using the IDT hydration review observation to include but not limited to: a. Resident's risk factors for dehydration. b. Resident's self-performance with fluids. c. Physical assessment including mucous membranes, skin turgor. d. Current labs/electrolytes. e. Hydration interventions. 3. If IDT hydration review deems that a hydration plan is necessary, the plan should be individualized to the resident<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | such as additional 240 mL of fluids each shift, additional 120 mL fluids at med pass, extra fluids identified on tray ticket, specifics based on resident preferences, labs, or therapy screen.7. Fluid intake will be planned to include at least 480 mL per meal for each resident.9. Fresh water or other preferred beverages will be passed to all residents, unless medically contraindicated, on each shift.10. A variety of additional fluids will be offered at various times throughout each shift (medication pass, activities, and per resident request). 11. Nursing staff is responsible for documenting fluid intake at mealtimes in the EMR. 12. Nursing staff is responsible for documenting all other fluid intake in EMR for his/her assigned residents on each shift.3.1-46(2)(b) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>A. Based on observation, interview, and record review, the facility failed to follow physician orders to change, label and date oxygen supplies for 1 of 2 residents reviewed for respiratory services. (Resident 17)B. Based on observation, interview, and record review, the facility failed to implement physician orders for oxygen administration for 1 of 2 residents reviewed for respiratory services. (Resident 47)Findings include:A1. During an observation, on 9/4/25 at 10:21 a.m., Resident 17's portable oxygen tank and oxygen tubing bag hung on the back of a wheelchair in the memory care commons area. The oxygen tubing bag was labeled with Resident 17's name, room number, had instructions that indicated portable, and was dated 8/18/25. The portable oxygen tubing was not dated. An oxygen concentrator sat behind a recliner where Resident 17 was sitting in, in the memory care commons area. The oxygen tubing bag hung on the back of the concentrator. The oxygen tubing bag was labeled with Resident 17's name, room number, and instructions that indicated oxygen, and was dated 8/18/25. The concentrator oxygen tubing was not dated. No humidifier bottle was present on the concentrator.During an observation, on 9/5/25 at 11:16 a.m., Resident 17's portable and concentrator oxygen bags remained dated 8/18/25. Both sets of oxygen tubing remained undated and unlabeled.Resident 17's clinical record was reviewed on 9/5/25 at 11:00 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure, and dementia.Current orders included Resident 17 utilized supplemental oxygen at 2 liters per minute via nasal cannula and the oxygen tubing and humidity was to be changed weekly on Sundays on night shift.An 8/12/25, quarterly, Minimum Data Set (MDS) indicated Resident 17 received oxygen therapy.During an interview, 9/05/25 at 12:02 p.m., LPN 16 indicated that Resident 17's portable and concentrator bags were dated 8/18/25, neither oxygen tubing was labeled or dated, and a humidity bottle was not on the concentrator. Tubing and bags were to be changed every Sunday, and it was not good that the dates on the bags reflected 8/18/25.During an interview on 9/5/25 at 12:13 p.m., the DON indicated oxygen tubing and bags were changed weekly on Sundays on the night shift. Nursing staff initialed Resident 17's treatment administration history on 8/24/25 and 8/31/25 and indicated that Resident 17's oxygen tubing and humidity were changed on those dates, but with the bags dated 8/18/25, the electronic record was not correct.During an interview, on 9/5/25 at 4:13 p.m., the Regional Director of Nursing Services indicated the facility did not have a respiratory or oxygen tubing policy regarding oxygen bag changes and concerns identified would be considered infection control.B 1. During an interview, on 9/3/25 at 11:43 a.m., an oxygen concentrator sat between the head of Resident 47's bed and her recliner. Resident 47 indicated she wore oxygen at night because she had sleep apnea and her oxygen levels dropped at night. She wore oxygen during the day as needed if she was short of breath. An oxygen tubing bag hung on the concentrator. The bag contained undated and unlabeled oxygen tubing and was labeled with Resident 47's name, room number, had instructions that indicated oxygen at night, and was dated 8/18/25.During an observation, on 9/5/25 at 10:05 a.m., Resident 47's oxygen bag remained dated 8/18/25. The oxygen tubing remained undated and unlabeled. No humidifier bottle was present on the concentrator.Resident 47's clinical record was reviewed on 9/5/25 at 1:50 a.m. Diagnoses included acute respiratory failure, acute pulmonary edema, obstructive sleep apnea, and hypertensive heart disease with heart failure. The electronic record lacked an order for oxygen use. An 8/5/25, quarterly, Minimum Data Set (MDS) indicated Resident 47 had moderate cognitive impairment. A care plan, dated 3/21/25, indicated that Resident 47 had potential for impaired gas exchange related to acute respiratory failure, obstructive sleep apnea, history of pneumonia, and resident becomes short of breath when lying flat. Interventions included administering oxygen as ordered (3/21/25).During an interview, on 9/5/25 at 11:54 a.m., LPN 16 indicated Resident 47 had worn oxygen at night previously but was unable to locate a current or past order for oxygen administration, and she was unsure if Resident 47 continued to wear oxygen at night. LPN 16 thought Resident 47's oxygen was implemented as a nursing measure on 6/23/25 when the resident exhibited<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a drop in her oxygen saturation level and went to the emergency room. At 12:04 p.m., LPN 16 confirmed an oxygen concentrator was present in Resident 47's room and the oxygen bag was dated 8/18/25. LPN 16 questioned Resident 47 if she wore oxygen and Resident 47 indicated she wore oxygen every night and sometimes during the day if she needed it. She had worn oxygen at night for years due to having sleep apnea.During an interview, on 9/5/25 at 12:13 p.m., the DON indicated oxygen administration required an order and a care plan in place. Oxygen was able to be applied as a nursing intervention if a resident demonstrated a change of condition and required supplemental oxygen. Immediate notification to the provider was expected if the nurse implemented oxygen so further instructions and orders could be received. The DNS did not believe Resident 47 utilized oxygen at night and felt the concentrator was not removed when she went to the hospital in June.During an interview, on 9/5/25 at 4:27 p.m., RN 19 indicated Resident 47 intermittently wore oxygen at night. As a nurse, he had checked her oxygen saturation levels but he did not place the oxygen on her, as Resident 47 was capable and applied and removed the oxygen herself.During an interview, on 9/5/25 at 4:41 p.m., CNA 20 indicated Resident 47 wore oxygen most nights. The resident removed oxygen tubing to go to the bathroom and would put it back on after she returned to bed. CNA 20 would remind Resident 47 to reapply oxygen if the resident forgot to put it back on.During an interview on 9/8/25 at 11:39 a.m., Resident 47 indicated that the oxygen concentrator was removed from her room two days ago. She voiced her displeasure due to having been on oxygen since 2011 for sleep apnea and heart issues. She had slept in her recliner since the oxygen was removed because she was short of breath when she laid flat. She had oxygen for years and an oxygen company came to her home and checked the machine out and the people here took machine away without an explanation other than she changed rooms and was not able to have O2 anymore.A current policy, last revised April 2023, titled Oxygen Therapy, provided by the Administrator on 9/9/25 at 4:05 p.m., indicated the following: .Procedure: 3. The nurse will coordinate the oxygen therapy services as ordered by the residents physician.A current policy, last revised on September 2025, titled MatrixCare Physician Orders Policy, provided by the Administrator on 9/9/25 at 4:05 p.m., indicated the following: MatrixCare Physician Orders: All new orders will be entered into MatrixCare Physician Orders and verified by a licensed nurse.Monthly Order Re-Caps.b. Nursing managers and/or designated nurse will review the physician order report (re-caps) for accuracy, order omission, and obtain any necessary order clarifications.d. Nursing managers and/or designated nurses will ensure that all telephone orders from the month prior on the physical chart are entered into and correctly match the MatrixCare Physician Orders Report.3.1-47(6) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to dispose of unlabeled and unused medications for 2 of 2 medication carts reviewed for medication storage and labeling. (100 Hall Medication Cart and Memory Care Unit Medication Cart) Findings include:1. During a medication storage observation of the Memory Care Unit Medication Cart, accompanied by LPN 16, on [DATE] at 9:50 a.m., a loose pill was found on the bottom of the second drawer. The pill was blue with marking of G on the pill.A small white oblong pill with the markings of K 31 was found on the bottom of the third drawer.During the observation, LPN 16 indicated the loose pills needed to be destroyed in the drug destruction solution.2. During a medication storage observation of the 100 Hall Medication Cart, accompanied by the Assistant Director of Nursing (ADON) on [DATE] at 11:20 a.m., an insulin pen for Resident 42 was undated with an open date. Four loose pills were found on the bottom of the second drawer, toward the back of the cart. The first pill was light pink with markings of 894 and 5 on the pill. The second pill was quartered with no visible markings. The third pill was white with markings of TCL/340. The fourth pill was orange with markings of PLIVA 467.The third drawer contained three loose pills. The first pill was white with markings of LS/85. The second and third were yellow quartered pills with no visible markings.The fourth drawer was pulled completely out, and 10 loose pills were found. The first pill was white and oval with markings of APO/A10. The second pill was round and pink with markings of PAL 6. The third pill was round and light pink with markings of 30. The fourth pill was white with markings of C/12. The fifth, sixth, and seventh pills were capsules with markings of IP 101. The eighth was a round orange pill with markings of 39/H. The ninth pill was small and white with markings of TV/51. The tenth pill was a pink half tablet with markings of GM.During the observation, the ADON indicated the pills needed to be destroyed in the drug destruction solution. Insulin pens needed to have an open date written on the pen. The insulin pen would be destroyed. Five residents received insulin from the 100 Hall Medication Cart.During an interview, on [DATE] at 12:35 p.m., the DON indicated insulin pens needed to be dated as soon as the pen was opened. Any loose medications need to be destroyed in the drug destruction solution. Medication carts were cleaned weekly, with the pharmacy coming monthly to check medication carts.A current policy, titled Storage and Expiration Dating of Medication and Biologicals, provided by the Administrator, on [DATE] at 8:49 p.m., indicated the following: .11. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law 3.1-25(j) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on record review and interview, the facility failed to implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies identified during a post survey revisit survey. Finding includes:Review of the Summary Statement of Deficiencies for the facility's last annual recertification and licensure survey, completed on 9/9/25, indicated the facility had deficiencies cited that included oxygen therapy and medication storage.During an interview, on 11/25/25 at 2:20 p.m., the Administrator indicated the Quality Assessment and Assurance (QAA) committee met on October 23, 2025 and reviewed the annual survey results and the plan of corrections (POC) that was put into place. Regular meetings were held and felt the facilities QAPI processes of tracking and trending were effective.During an interview, on 11/25/25 at 2:50 p.m., the Administrator indicated the POC binder included everything that pertained to the annual survey deficiencies. The audits were performed as scheduled. She felt the weekly audits were fine, but moving forward to the monthly audits, problems had occurred. Due to the recurrent identified problems, the audit sheets were going to be revamped to add a certain number of residents or medication carts to be audited. Audits needed to be more detailed, rather than just a spot check.Repeat concerns regarding oxygen therapy and labeling of drugs and biologicals reviewed during medication storage were cited during 9/9/25 survey as follows:The facility failed to dispose of unlabeled and unused medications for 2 of 3 medication carts reviewed for medication storage and labeling. (100 Hall Medication Cart and 300 Hall Medication Cart)The facility failed to follow physician orders to change, label and date oxygen supplies for 6 of 7 residents reviewed for respiratory services. (Residents 9, 22, 24, 46, 55, 63)An undated facility policy titled, Policy, provided by the Administrator on 11/25/25 at 3:19 p.m., indicated the following: It is the policy of American Senior Communities that each facility actively participates in a formalized and documented Quality Assurance and Performance Improvement Process (QAPI).The QAPI Process includes auditing, trending, monitoring, action planning, evaluating, and follow up .QAPI will involve systemic change related to that particular system rather than focusing on a particular part.Goals.To demonstrate systemic identification, reporting, investigating, analysis, and prevention of adverse events, which includes ongoing abuse prevention measures.Cross reference F695.Cross reference F761.3.1-52(b)(2) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were followed during dining services for 4 of 5 residents observed in the memory care dining room. (Residents 1, 21, 22, and 32) Finding includes: During a continuous dining observation, on 9/3/25 from 11:57 a.m. to 12:45 p.m., the following food handling and infection prevention and control concerns were observed:CNA 10 served Resident 32 her meal tray. CNA 10 used her left barehanded fingertips to apply pressure to the top sandwich bun of Resident 32's chicken patty sandwich. CNA 10 held the bun in place with her fingertips and used a knife in her right hand to cut Resident 32's sandwich in half. CNA 10 served Resident 1 her meal tray. CNA 10 removed the top sandwich bun of Resident 1's chicken patty sandwich with her right bare hand and sat the bun upright on the edge of Resident 1's plate. Using both hands, CNA 10 opened a ketchup packet. CNA 10 picked up the top bun and placed it in the palm of her left bare hand. CNA 10 squirted the ketchup from the packet onto the top bun. CNA 10 picked up a knife with her right hand, spread the ketchup on the bun, and placed the top bun on top of the chicken patty. CNA 10 applied pressure to the top sandwich bun with the fingertips of her left bare hand to secure the bun in place and used a knife in her right hand to cut the sandwich in half. CNA 10 served Resident 21 her meal tray. CNA 10 picked up the top sandwich bun with her left bare hand. The top bun was placed upright on the meal tray. Using both hands, CNA 10 opened a mayonnaise packet. CNA 10 picked up the top bun and placed it in the palm of her left bare hand. She squirted the mayonnaise from the packet onto the top bun. She placed the top bun back on the sandwich, applied pressure to the top bun with the fingertips of her left hand to secure the bun in place, and used a knife in her right hand to cut the sandwich in half. Indentions were left in the bun from the pressure applied by CNA 10's fingertips. CNA 10 served Resident 22 her meal tray. CNA 10 picked up the top sandwich bun with her left bare hand. Using both hands, CNA 10 opened a ketchup packet and squirted the ketchup on the top bun. She placed the top bun back on the sandwich, applied pressure to the top bun with the fingertips of her left hand to secure the bun in place, and used a knife in her right hand to cut the sandwich in half. During the observation, CNA 10 indicated to the Regional Consultant that she wasn't sure of the proper technique to assist residents with their sandwiches. During an interview, on 9/3/25 at 12:56 p.m., CNA 10 indicated she was not to touch the bread when she served the residents their sandwiches. She performed hand hygiene between residents and thought it was okay to touch food items. During an interview, on 9/5/25 at 4:19 p.m., the DON indicated staff were not to handle food items with their bare hands. Staff were expected to use a barrier between their hands and food items, or use eating utensils, such as a fork or knife, when food items were handled. A current facility policy, revised in May 2025, provided by the Administrator on 9/8/25 at 10:15 a.m., titled General Food Preparation and Handling, indicated the following: .PROCEDURE: 7. Bare hands should never touch raw or ready to eat food directly. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid bare hand contact of foods. 3.1-18(a) |