STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200		ILDING NG	ONSTRUCTION	(X3) DATE COMPL 11/07/	ETED
	PROVIDER OR SUPPLIER			1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 11/07 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency University Nursing compliance with En Requirements for M Participating Provide	27/24 20107 255200 290330 Preparedness survey, Center was found in nergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR has a capacity of 75 and had a time of this survey.	E 00	00			
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 11/07 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety 0	200107 55200 290330 Code survey, University of found not in compliance with	K 00	000			
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE		TITLE		(X6) DATE

(X6) DATE

Rachel Bishir **Executive Director** 11/25/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		01	COMPL	
		155200	B. WING			11/07	/2024
	PROVIDER OR SUPPLIER			1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		EFIX ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facilit Type V (000) consts sprinklered. The fa with smoke detection open to the corridor detectors in the resist capacity of 75 and b of this survey. All areas where the	the LSC IDENTIFYING INFORMATION 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. The etion and was fully edility has a fire alarm system on in the corridors and areas and battery operated smoke dent rooms. The facility has a final a census of 67 at the time residents have customary ered. All areas providing		IAG	DEPCIENCTI		DATE
K 0211 SS=E	-						
Bldg. 01	failed to ensure 1 of laundry room met the LSC 7.2.1.2.3.2 who means of egress shamm) in clear width, affect staff in the law. Findings include: Based on observation Director on 11/07/2 laundry room door with laundry room door w	on and interview, the facility 2 egress doors from the ne clear width according to ich states door openings in all be not less than 32 in. (810). This deficient practice could undry room. On with the Maintenance 4 at 11:29 a.m., the clean side would only open ½-way due to the door. This condition	K 021	1	K 211 Means of Egress What corrective actions will be accomplished for those reside found to have been affected be deficient practice. No residents were found to affected. Shelf inside clean laundry room found to obstruct door was removed by Mainter director on 11/12/2024. Education to be complete with environmental staff r/t keet the door clear of obstruction a	nts y the to be nance d eping	12/12/2024

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155200	B. WING		11/07/2024
			<u> </u>	_	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				S UNIVERSITY BLVD	
UNIVER	SITY NURSING CE	NTER	UPLAN	ND, IN 46989	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	` `	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1110	+	ridth of 32 inches by half.	1710	maintaining full ananing functi	
		iew at the time of observation,		maintaining full opening functi	OII
				by 12/6/2024.	
		irector agreed the door would		How other residents having th	
	not fully open to th	e required width of 32 inches.		potential to be affected by the	
	TEL: C: 1:	the state of the s		same deficient practice will be	•
	_	eviewed with the Administrator		identified and what corrective	
		ce Director during the exit		action will be taken.	
	conference.			All residents have the	
				potential to be affected.	
	3.1-19(b)			Maintenance director or	
				designee to complete audit of	all
				aisles, passageways, corridor	S,
				exit discharges, exit locations,	,
				and accesses to ensure all me	eans
				of egress are free from	
				obstruction.	
				Education to be complete	d
				with all staff r/t importance of	
				keeping all means of egress fi	ree
				from obstruction by 12/6/2024	
				What measures will be put into	
				place or what systemic chang	
				will be made to ensure that the	
				deficient practice does not rec	
				Education to be complete	
				with all staff r/t importance of	
				keeping all means of egress fi	ree
				from obstruction by 12/6/2024	
				Maintenance director or	
				designee to round daily to ens	sure
				all means of egress are	,,,,,
				unobstructed.	
				Obstructions identified will	ll he
				cleared immediately.	11 50
				How the corrective action will	ho
				monitored to ensure the defici	
				practice will not recur, what qu	-
				assurance program will be put	t into
				place.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

		IDENTIFICATION NUMBER 155200		ILDING	01	COMPL 11/07/	ETED
	ROVIDER OR SUPPLIER			1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0324 SS=C Bldg. 01	interview, the facilit maintain equipment hood extinguishing cooking equipment NFPA 96. NFPA 96 appliances requiring moved, modified, or re-evaluation of the the system installer otherwise allowed be extinguishing system are approved existing permitted to be contapproved method the appliances were retulocation after they have the contage of the cont	eaning. Section 10.1.2 states that produces grease-laden	K 03		corrective action will be monitor via facility QAPI program, with meetings being held at least bi-monthly, and is overseen by Executive Director. Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure complianaby what date the systemic changes will be completed. 12/6/2024. K 324 Cooking Facilities What corrective actions will be accomplished for those reside found to have been affected by deficient practice. All residents in the main dining were found to be affected Maintenance director place distinguished markings per post to ensure that all cooking equipment is returned to the designated location after they been moved for maintenance accleaning on 11/20/2024. Education to all culinary sto be provided by 12/06/2024 accooking equipment placement markings. How other residents having the	ot the ced. edd. edd icty have and taff c/t and	12/06/2024 ge 4 of 17

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DEPARTMEN'	T OF HEALTH AND HU	JMAN SERVICES				FOI	RM APPROVED	
ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155200	B. W	ING		11/07	/2024	
				CTREET	ADDRESS SITU STATE ZID SOD			
NAME OF I	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP COD			
LINII\/ED		NTED			UNIVERSITY BLVD			
UNIVER	SITY NURSING CE	ENTER		UPLAN	ID, IN 46989			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	vapors and that mi	ght be a source of ignition of			potential to be affected by the			
	grease in the hood,	, grease removal device, or duct			same deficient practice will be			
	shall be protected l	by fire-extinguishing			identified and what corrective			
	equipment. This do	eficient practice affects staff in			action will be taken.			
	the kitchen and all	residents in the main dining			All residents that enter the	9		
	room.				main dining area have the pot	ential		
					to be affected.			
	The findings inclu	de:			Culinary manager or desi	gnee		
					to complete audit of cooking			
	Based on records r	review with the Maintenance			equipment and markings to er	sure		
	Director and Admi	inistrator on 11/07/24 at 12:40			proper placement.			
	p.m., the kitchen e	quipment policy indicated all			Education to all culinary s	taff		
	cooking equipmen	t shall be put back in the			to be provided by 12/06/2024	r/t		
	designed location l	by aligning the cooking			cooking equipment and marking	ngs		
	equipment with the	e markings on the floor. Based			placement.			
	on observation at 1	11:49 a.m., all cooking			What measures will be put into	0		
	equipment in the n	nain kitchen were covered by			place or what systemic change	es		
	the fire suppression	n system, but was not provided			will be made to ensure that the	е		
	with markings on t	the floor according to the			deficient practice does not rec	ur.		
	facility's policy to	ensure cooking appliances were		Education to all culinary staff				
	returned to the app	roved design location after			to be provided by 12/06/2024	r/t		
	they had been mov	ved for maintenance and			cooking equipment and marki	ngs		
	cleaning. Based on	n an interview during			placement.			
		cords review, the Maintenance			Culinary manager or design	gnee		
		inistrator stated there was a			to check cooking equipment a	nd		
	written policy for o	cooking equipment, but the floor			markings daily to ensure prop	er		
		rkings to ensure cooking			placement.			
		turned to an approved design			Cooking equipment or			
		had been moved for			markings that are found to be	out		
	maintenance and c	leaning.			of designated location will be			
					returned immediately or after			
		eviewed with the Administrator			maintenance/cleaning. Missin	g		
	and the Maintenan	ce Director during the exit			distinguished markings will be			
	conference.				replaced immediately.			
					How the corrective action will	be		
	3.1-19(b)				monitored to ensure the defici	ent		

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place.

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practice will not recur, what quality assurance program will be put into

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DEPARTMENT OF HEALTH AND HUM	MAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>01</u>	COMPLETED
	155200	B. WI	NG	11/07/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD	•
UNIVERSITY NURSING CE	NTER		UPLAND, IN 46989	

DINIVER	SITT NURSING CENTER	OPLAND, IN 40909				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 0351 SS=E	NFPA 101 Sprinkler System - Installation		corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.			
Bldg. 01	Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads in the 300-hall storage closet were in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1which states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 20 residents in one smoke compartment.	K 0351	K351 Sprinkler System-Installation What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Potential of 20 residents were found to be affected. Maintenance director removed top shelf in the 300-hall storage closet on 11/12/2024 to ensure 18" clearance of sprinkler head. Education to all staff r/t storage of supplies and sprinkler head obstruction to be completed by 12/06/2024. How other residents having the potential to be affected by the	12/06/2024		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	ì í	ILDING	nstruction 01	(X3) DATE COMPI 11/07	
	PROVIDER OR SUPPLIER SITY NURSING CE			1564 S	ADDRESS, CITY, STATE, ZIP COI UNIVERSITY BLVD D, IN 46989)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
	Director on 11/07/2 closet in the 300-ha of the sprinkler. Base of observation, the the sprinkler head whave an 18-inch cle closet.	on with the Maintenance 4 at 12:15 p.m., the storage Il had storage within 8 inches sed on an interview at the time Maintenance Director agreed vas obstructed and did not arance from the storage in the viewed with the Administrator be Director during the exit			same deficient practice videntified and what correaction will be taken. All residents have the potential to be affected. Maintenance directed designee to conduct an astorage areas to ensure top shelf do not obstruct heads. Education to all staff storage of supplies and shead obstruction to be consulted by 12/06/2024. What measures will be perfected by 12/06/2024. What measures will be perfected by 12/06/2024. What measures will be perfected by 12/06/2024. Maintenance directed designee of supplies and shead obstruction to be consulted by 12/06/2024. Maintenance directed designee to check storage daily to ensure sprinkler unobstructed. Sprinkler heads that found to be obstructed we cleared immediately. How the corrective action monitored to ensure the practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice will not recur, when assurance program will be practice. Ongoing compliance corrective action will be recurred to the practice will not recurr	or or audit of all items on sprinkler fr/t sprinkler ompleted out into changes nat the ot recur. fr/t sprinkler ompleted or or ge closets heads are vill be a will be deficient nat quality be put into e with this monitored of the control of the co	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	· /	JILDING	onstruction 01	(X3) DATE S COMPL 11/07/	ETED
	ROVIDER OR SUPPLIER			1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed. 12/6/2024.	ot	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors						
	failed to ensure 2 of doors in the facility suitable for keeping impediment to closi the passage of smok could affect 4 reside. Findings include: Based on observation Director on 11/07/2 doors to resident room into the frame when the time of observation stated the corridor downled not latch into latch was stuck insiderame. This finding was resident to the state of the corridor of the state	on and interview, the facility of 40 resident room corridor were provided with a means the door closed, had no ng, latching, and would resist the. This deficient practice ents in rooms 203 and 321. On with the Maintenance 4 at 11:20 a.m., the corridor coms 203 and 321 did not latch the tested. Based on interview at ion, the Maintenance Director cloors for rooms 203 and 321 of the door frame because the detected the door and a bent door wiewed with the Administrator the Director during the exit	K 0:	363	What corrective actions will be accomplished for those reside found to have been affected by deficient practice. 4 residents were found to affected. Maintenance director serv doors to room 203 and 312 on 11/20/2024 to ensure proper lawhen closed. Education to all staff by 12/06/2024 r/t reporting the fair of proper latching of resident of when closed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance director or	nts y the be iced atch lure loors	12/06/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/07/2024
	PROVIDER OR SUPPLIE SITY NURSING CE		1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD ID, IN 46989	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF DEPUTE VING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	
TAG	3.1-19(b)	R LSC IDENTIFYING INFORMATION	TAG	designee to conduct audit of a resident doors for proper latch when closed. Education to all staff by 12/06/2024 r/t reporting the far of proper latching of resident when closed. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not receive Education to all staff by 12/06/2024 r/t reporting the far of proper latching of resident when closed. Maintenance director or designee to round daily to ensure the proper latching of resident doors when closed. Resident doors noted to latch properly when closed with corrected immediately. How the corrective action will monitored to ensure the deficipractice will not recur, what quassurance program will be purplace. Ongoing compliance with corrective action will be monit via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is met, an action plan will be	ning sillure doors ooles ecur. sillure doors sure t not II be be ient uality t into of this cored on the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLE	ETED
		155200	B. WI	NG		11/07/2	2024
						<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
LINID (ED)		NTED			UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	INTER		UPLAN	ID, IN 46989		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					developed to ensure complian	nce.	
					By what date the systemic		
					changes will be completed.		
					12/6/2024.		
			İ				
K 0372	NFPA 101						
SS=F	Subdivision of Bu	ilding Spaces - Smoke					
Bldg. 01	Barrie						
	Based on observati	on, records review, and	K 0.	372	K372 Subdivision of Building	g	12/06/2024
	interview, the facil	ity failed to ensure penetrations			Spaces-Smoke Barriers		
	caused by the passa	age of wires, pipes, and			What corrective actions will be	Э	
	conduits through 4	of 4 smoke barrier walls were			accomplished for those reside	ents	
	protected to mainta	in the smoke resistance of			found to have been affected b	y the	
	each smoke barrier	and to ensure listed firestop			deficient practice.		
	systems or devices	were used to seal			All residents were found t	o be	
	penetrations. LSC	Section 8.5.6.2 requires			affected.		
	penetrations for cal	bles, cable trays, conduits,			Maintenance Director or		
	pipes, tubes, vents,	wires, and similar items to			designee to ensure all		
	accommodate elect	trical, mechanical, plumbing,			penetrations in smoke barriers	s on	
	and communication	ns systems that pass through a			100-hall, 200-hall, 300-hall, ar	nd	
	wall, floor, or floor	c/ceiling assembly constructed			above the drop ceiling and in	the	
	as a smoke barrier,	or through the ceiling			attic of the dining hall are seal	led	
	membrane of the ro	oof/ceiling of a smoke barrier			with a firestop system or device	ce	
	assembly, shall be	protected by a system or			tested in accordance with AS	ГΜ	
	material capable of	restricting the movement of			E 814. To be corrected no lat	:er	
	smoke.				than 12/06/2024.		
	LSC 8.2.3.1 states	the fire resistance of structural			Education for Maintenand	е	
	elements and build	ing assemblies shall be			Director r/t penetrations and		
	determined in acco	rdance with test procedure set			proper sealing with firestop		
		19, Standard Test Methods for			system or device.		
		ing Construction and Materials,			How other residents having th	e	
		Standard for Fire Tests of			potential to be affected by the		
		tion and Materials; other			same deficient practice will be	;	
		ods; or analytical methods			identified and what corrective		
		HJ. The AHJ requires			action will be taken.		
	_	oke barriers to be sealed with a			All residents residing in the	ne	
		device tested in accordance			facility have the potential to be	э	
	with ASTM E 814.				affected.		
1	This deficient pract	tice affects all residents.			Maintenance Director or		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	r í	JILDING	ONSTRUCTION 01		SURVEY LETED 7/2024	
	PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE	
	Findings include:				designee to conduct audit o smoke barriers to ensure pr sealing of penetrations.			
	Director on 11/07/2 p.m., the following penetrations filled of ASTM E 814 were a) Above the drop 100-hall smoke wa around wires, and I caulk, and grey cau b) Above the drop 200-hall smoke wa around wires and p white caulk, and grey cau d) Above the drop 300-hall smoke wa 3-inch cutout, and caulk, and grey cau d) Above the drop dining hall smoke wa around wires and p white caulk, and grey cau d) Above the drop dining hall smoke wa around wires and p white caulk, and grey cau documentation was compound, white cau ASTM E 814.	ceiling and in the attic of the ll had 1/4-inch unsealed gaps had joint compound, white alk to seal penetrations. ceiling and in the attic of the ll had 1/2-inch unsealed gaps hipes, and had joint compound, rey caulk to seal penetrations. ceiling and in the attic of the ll had an unsealed 6-inch by had joint compound, white alk to seal penetrations. ceiling and in the attic of the lk to seal penetrations. ceiling and in the attic of the wall had 1/2-inch unsealed gaps hipes, and had joint compound, rey caulk to seal penetrations. eview at 12:40 p.m. no serviced to show if the joint had a grey caulk were listed			What measures will be put in place or what systemic chart will be made to ensure that deficient practice does not reducation for Maintenan Director r/t penetrations and proper sealing with firestop system or device. Maintenance Director or designee to check smoke be per policy to ensure proper of any old or new penetrations. Smoke barrier penetrations found will be sealed with profirestop system asap. How the corrective action will monitored to ensure the definition practice will not recur, what assurance program will be place. Ongoing compliance will corrective action will be more via facility QAPI program, will meetings being held at leas bi-monthly, and overseen by executive Director.	nges the ecur. nce d erriers sealing ons. ions oper ill be ficient quality out into ith this nitored with		
	contained unsealed with material with E 814.	tor agreed all four smoke walls penetrations and were filled out the proper listing of ASTM reviewed with the Maintenance nistrator during the exit			Rounding tool will be completed weekly x's 3 week monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is met, an action plan will be developed to ensure compliance by what date the systemic	s not		
	3.1-19(b)				changes will be completed. 12/6/2024.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155200 B. WING 11/07/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1564 S UNIVERSITY BLVD UNIVERSITY NURSING CENTER **UPLAND. IN 46989** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0374 **NFPA 101** SS=F Subdivision of Building Spaces - Smoke Bldg. 01 Barrie Based on observation and interview, the facility K 0374 K374 Subdivision of Building 12/06/2024 failed to ensure 1 of 4 sets of smoke barrier doors **Spaces-Smoke Barriers** would restrict the movement of smoke for at least What corrective actions will be 20 minutes. LSC 19.3.7.8 requires doors in smoke accomplished for those residents barriers shall comply with LSC Section 8.5.4. LSC found to have been affected by the 8.5.4.1 requires doors in smoke barrier shall close deficient practice. the opening leaving only the minimum clearance All residents in the main necessary for proper operation. This deficient dining room are found to be practice could affect all residents that use the affected. main dining room. Maintenance Director adjusted the set of smoke barrier Findings include: doors in the dining room corridor to ensure proper self-closure with Based on observation with the Maintenance the activation of the fire alarm on Director on 11/07/24 at 11:25 a.m., the set of smoke 11/20/2024. barrier doors in the dining room corridor would How other residents having the not close due to one of the doors getting stuck on potential to be affected by the a high point on the floor. This condition would same deficient practice will be leave the smoke doors halfway open upon identified and what corrective activation of the fire alarm. Based on an interview action will be taken. during the time of observation, the Maintenance All residents residing in the Director stated the smoke door would not facility have the potential to be completely self-close. affected. Maintenance Director or This finding was reviewed with the Administrator designee to conduct audit of all and the Maintenance Director during the exit smoke barrier doors to ensure conference. proper self-closure with activation of the fire alarm. 3.1-19(b) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director or designee to check all smoke barrier doors routinely per policy to ensure proper self-closure with

activation of the fire alarm.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155200			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/07/2024		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
				Smoke doors found to no properly self-close with activa of the fire alarm will be correct asap. How the corrective action will monitored to ensure the deficing practice will not recur, what quassurance program will be purplace. Ongoing compliance with corrective action will be monit via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed. 12/6/2024.	tion ted be tient uality t into this ored n the		
K 0511 SS=E	NFPA 101 Utilities - Gas an	d Electric					

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hall.

Based on observation and interview, the facility

failed to ensure 1 of 1 electrical splices in the

service hall mechanical room were made in a

junction box. LSC 9.1.2 requires electrical wiring

and equipment to comply with NFPA 70, National

Electrical Code. Article 322.56 (A) states splices

deficient practice could affect staff in the service

shall be made in listed junction boxes. This

Bldg. 01

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K511 Utilities- Gas and Electric

accomplished for those residents

found to have been affected by the

No residents were found to be

Maintenance Director placed

junction box over spliced electrical

What corrective actions will be

deficient practice.

affected.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155200	(X2) MULTIPLE CO A. BUILDING B. WING	<u> </u>			
	PROVIDER OR SUPPLIER SITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Findings include:		wires to a light inside the mechanical room in the servic hall on 11/12/2024.			
	Based on observation with the Maintenance Director on 11/07/24 at 11:32 a.m., in the service hall mechanical room there were electrical wires spliced together connecting a light that was not contained inside a junction box. Based on an interview at the time of the observation, the Maintenance Director agreed there was an electrical splice that was not protected within a junction box. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Education for Maintenance Director r/t spliced wires to be properly covered with a junction box by 12/06/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance Director or designee to conduct audit of a connecting lights to ensure an splices are properly covered be junction box. What measures will be put inte place or what systemic change will be made to ensure that the deficient practice does not rece Maintenance Director or designee to check all connect lighting fixtures routinely per p to ensure any splices are cove properly with a junction box. Any spliced wires found without a junction box will be corrected immediately. How the corrective action will monitored to ensure the defici practice will not recur, what qu assurance program will be put place. Ongoing compliance with corrective action will be monite	e e e e e e e e e e e e e e e e e e e		
			via facility QAPI program, with			

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CENTERS FOR MEDICARE & MEDIC	CAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		1564 S	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD ID, IN 46989	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/07/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens Based on observation failed to ensure 2 of as a substitute for fi equipment with a hi NFPA-70/2011, 400 permitted in 400.7 fi not be used for (1) a This deficient practive residents in one smooth Findings include: Based on observation Director on 11/07/2 refrigerator (high populaged into a power office and a refriger multi-plug adaptor in an interview at the total maintenance Director on the control of	ent - Power Cords and on and interview, the facility c 2 power strips were not used xed wiring to provide power gh current draw. 0.8 state unless specifically elexible cords and cables shall as a substitute for fixed wiring. ice could affect up to 25	K 0920	meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed. 12/6/2024. K920 Electrical Equipment-Power Cords and Extension Cords What corrective actions will be accomplished for those reside found to have been affected by deficient practice. Up to 25 residents resider in one smoke compartment we found to be affected. Maintenance Director plug the appliances found in 2 officient directly into the wall per regulation 11/07/2024. Education provided to ED Culinary Director r/t properly plugging appliances directly in the wall outlet on 11/07/2024. How other residents having the potential to be affected by the same deficient practice will be	ne de

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155200		155200	B. WING			11/07/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			ID, IN 46989		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE.	DATE
	and a into multi-plu	ıg adaptor.			identified and what corrective		
	•				action will be taken.		
	This finding was re	viewed with the Administrator			All residents have the		
	and the Maintenance Director during the exit				potential to be affected.		
	conference.	S			All employees with offices	s to	
					be educated r/t r/t properly		
	3.1-19(b)				plugging appliances directly ir	ito	
					the wall outlet by 12/06/2024.		
					Maintenance Director or		
					designee to conduct audit in a	ıll	
					offices to ensure any high pov		
					draw equipment is plugged in		
					properly.		
					What measures will be put into	0	
					place or what systemic chang		
					will be made to ensure that the		
					deficient practice does not rec		
					Maintenance Director or		
					designee to check all offices		
					routinely per policy to ensure	anv	
					high current draw equipment i	-	
					plugged into the proper outlet.		
					Any high current draw		
					equipment not plugged into th	е	
					proper outlet will be corrected		
					immediately.		
					All employees with offices	s to	
					be educated r/t r/t properly		
					plugging appliances directly ir	ito	
					the wall outlet by 12/06/2024.		
					How the corrective action will	be	
					monitored to ensure the defici	ent	
					practice will not recur, what qu	uality	
					assurance program will be pu	t into	
					place.		
					Ongoing compliance with	this	
					corrective action will be monit		
					via facility QAPI program, with	1	
					meetings being held at least		
					bi-monthly, and overseen by t	he	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	r ′	LDING	onstruction 01	(X3) DATE COMPL 11/07/	LETED
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION				Executive Director. Rounding tool will be completed weekly x's 3 weeks monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is net, an action plan will be developed to ensure complian By what date the systemic changes will be completed. 12/6/2024.	not	

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