PRINTED: 12/27/2022

EPARTMENT OF HEALTH AND HUN	PARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	COMPLETED			
	155200	B. WI	NG	12/05/2022			
NAME OF BROWIDER OR CURRI IER			STREET ADDRESS, CITY, STATE, ZIP COD				

NAME OF P	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD				
UNIVERS	SITY NURSING CENTER		D, IN 46989			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000						
Bldg						
	An Emergency Preparedness Survey was	E 0000	University Nursing Center is			
	conducted by the Indiana Department of Health in		alleging compliance on 1.3.23 and			
	accordance with 42 CFR 483.73.		is requesting paper compliance for			
			the annual life safety code			
	Survey Date: 12/05/22		recertification and state licensure			
			survey.			
	Facility Number: 000107					
	Provider Number: 155200					
	AIM Number: 100290330					
	At this Emergency Preparedness survey,					
	University Nursing Center was found in					
	compliance with Emergency Preparedness					
	Requirements for Medicare and Medicaid					
	Participating Providers and Suppliers, 42 CFR					
	483.73. The facility has a capacity of 75 and had a					
	census of 62 at the time of this survey.					
	Quality Review completed on 12/05/22					
K 0000						
Bldg. 01						
3. 4.	A Life Safety Code Recertification and State	K 0000	University Nursing Center is			
	Licensure Survey was conducted by the Indiana	12 0000	alleging compliance on 1.3.23 and			
	Department of Health in accordance with 42 CFR		is requesting paper compliance for			
	483.90(a).		the annual life safety code			
			recertification and state licensure			
	Survey Date: 12/05/22		survey.			
	Facility Number: 000107					
	Provider Number: 155200					
	AIM Number: 100290330					
	At this Life Safety Code survey, University					
	Nursing Center was found not in compliance with					
	Requirements for Participation in					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Nicole Moore **Executive Director** 12/19/2022

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	î ´	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155200	B. WING		12/05/2022	
	PROVIDER OR SUPPLIER		1564	T ADDRESS, CITY, STATE, ZIP COD S UNIVERSITY BLVD IND, IN 46989		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		, 42 CFR Subpart 483.90(a),				
	•	re and the 2012 edition of the				
		etion Association (NFPA) 101,				
Life Safety Code (LSC), Chapter 19, Existing						
	Health Care Occupa	ancies and 410 IAC 16.2.				
	This one story facili	ity was determined to be of				
		ruction and was fully				
		cility has a fire alarm system				
		on in the corridors and areas				
		s and battery operated smoke				
detectors in the resident rooms. The factor capacity of 75 and had a census of 62 at		dent rooms. The facility has a				
		nad a census of 62 at the time				
	of this survey.					
		residents have customary				
	-	ered. All areas providing re sprinklered. The facility had				
	-	aintenance supplies that was				
	not sprinklered.	antichance supplies that was				
	not sprinktered.					
	Quality Review con	npleted on 12/05/22				
K 0300	NFPA 101					
SS=F	Protection - Other					
Bldg. 01	Protection - Other					
	List in the REMAR	RKS section any LSC				
	Section 18.3 and	19.3 Protection				
	requirements that	are not addressed by the				
		out are deficient. This				
		with the applicable Life				
	,	FPA standard citation,				
		d on Form CMS-2567.	17.0200	K 200 Breate of the confidence	01/02/2022	
		view and interview the facility	K 0300	K 300 Protection - Other	01/03/2023	
		replacement for 45 of 45		What corrective action(s) will	ho	
	according to manufa	oke alarms were conducted		What corrective action(s) will accomplished for those reside		
	_	. 101 in 4.6.12.3 states existing		found to have been affected by		
		obvious to the public, if not		deficient practice;	,y u i c	
	•	le, shall be maintained. NFPA		· - Expired battery operat	ed	

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STATEMEN	T 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		12/05/	2022
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
	Г		1		, I	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		avad	DATE
		nce and Tests. Fire-warning			smoke alarms have been rem and disposed of.	ovea	
	equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and				and disposed or 45 of 45 battery operat	od	
					smoke alarms have been labeled		
					with install date, tested and	ileu	
	maintenance progra	-			installed.		
		s Code and conform to the					
		eturer's published instructions.					
		ice could affect all residents.			How other residents having th	е	
	•				potential to be affected by the		
	Findings include:				same deficient practice will be		
					identified and what corrective		
	Based on records review with the Maintenance				action(s) will be taken;		
	Director and Administrator on 12/05/22 at 9:42				· All residents have the		
		rer's published instructions for			potential to be affected by the		
		tated, "replace unit within 10			deficient practice.		
	1 -	date." The date recorded on			<ul> <li>Audit was completed of a</li> </ul>		
		m was 04/21/12. Based on			battery operated smoke alarm		
		e of records review, the			ensure all have been inspecte		
		tor agreed the smoke alarms			tested and are maintained per		
		n years and stated new smoke			manufacturer's instructions wi	th	
	alarms will be insta	iled.			no additional concerns noted.		
	The finding was rev	viewed with the Administrator			What measures will be put into	_	
		e Director during the exit			What measures will be put into place or what systemic change		
	conference.	o Director during the exit			will be made to ensure that the		
	Tomeronee.				deficient practice does not rec		
	3.1-19(b)				· - Maintenance/designee		
					round monthly to ensure all		
					battery operated smoke alarm	ıs	
					are in compliance.		
					· - Battery operated smok	e	
					alarms due for replacement th		
					following month will be replace	ed	
					during monthly rounds.		
					How the corrective action(s) w		
					monitored to ensure the defici		
					practice will not recur, what qu	-	
			1		assurance program will be put	t into	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155200	B. WI	NG	-	12/05/	/2022
				_	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
	NT / NU IDOINIO OF	NITED			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NIER	UPLAND, IN 46989				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'L	DATE
					place;		
					- Ongoing compliance w	ith	
					this corrective action will be		
					monitored via facility QAPI		
					program, with meetings being	held	
					monthly, and is overseen by the		
					Executive Director.		
					· - CQI tool identified Bat	tery	
					Operated Smoke Alarms will b	-	
					completed weekly x 4 weeks,		
					monthly times 6 months, and		
					quarterly thereafter until		
					compliance is achieved.		
					- If Threshold of 100% is	not	
					met, an action plan will be		
					developed to ensure complian	ce.	
					By what date the systemic		
					changes will be completed;		
					Completion date: 1/3/23		
					Paper Compliance is requeste	ed.	
K 0345	NFPA 101						
SS=E	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm System	า - Testing and					
	Maintenance						
		m is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
		n acceptance, maintenance				ļ	
	and testing are rea	•					
		FPA 70, NFPA 72				ļ	
		on and interview, the facility	K 0	345	K 345 Fire Alarm System –	ļ	01/03/2023
		f 9 manual fire alarm boxes (pull			Testing and Maintenance	ļ	
	· ·	bstructed. LSC 9.6.1.3 states a				ļ	
		equired for life safety shall be			What corrective action(s) will be		
	installed, tested, and	d maintained in accordance			accomplished for those reside	nts	

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with the applicable requirements of NFPA 70,

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found to have been affected by the

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STATEMEN	T 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		12/05/	2022
		l	<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			UNIVERSITY BLVD		
	SITY NURSING CE	NTED			D, IN 46989		
UNIVERS	ON THE PROPERTY OF	IN I EIX		UPLAN	D, IIN 40909		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		Code, and NFPA 72, National	1		deficient practice;		
	_	naling Code. NFPA 72 2010			· - Items immediately		
		es manual fire alarm boxes shall			removed from in front of pull		
		they are conspicuous,			station		
		ccessible. This deficient			l., "		
	-	t 25 residents in one smoke			How other residents having th		
	compartment.				potential to be affected by the		
	Findings 1 1 1				same deficient practice will be	!	
	Findings include:				identified and what corrective		
	Događan -1	on with the Maintenance			action(s) will be taken;		
		Iministrator on 12/05/22 at			· All residents have the		
		station in the dining hall had a			potential to be affected by the		
	_	in front of the pull station and			deficient practice.  Audit was completed of a	,II	
		n direct access. Based on			manual fire alarm boxes (pull	111	
		es of observation, the			stations) and no additional		
		for agreed the pull station was			obstructions were noted.		
		s and removed the items in			obstructions were noted.		
	front of the pull stat				What measures will be put into	2	
	nont of the pun stat	non.			place or what systemic change		
	The finding was rev	viewed with the Administrator			will be made to ensure that the		
	-	e Director during the exit			deficient practice does not rec		
	conference.				· - All Staff in-service to be		
					completed by 1/3/23 per ED o		
	3.1-19(b)				not obstructing pull stations.		
					· Maintenance/designee	e to	
					round daily to ensure pull stati		
					are not obstructed.		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici-		
					practice will not recur, what qu	ıality	
					assurance program will be put	-	
					place;		
					<ul> <li>Ongoing compliance with</li> </ul>	1	
					this corrective action will be		
					monitored via facility QAPI		
					program, with meetings being	held	
					monthly, and is overseen by th	ne	
			1		Executive Director.		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	
		155200	B. WI	NG		12/05/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
UNIVERS	SITY NURSING CE	NTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	· CQI tool identified Fire A	lorm	DATE
					System will be completed wee x 4 weeks, monthly times 6		
					months, and quarterly thereaft	er	
					until compliance is achieved.	-4	
					<ul> <li>If Threshold of 100% is n met, an action plan will be</li> </ul>	Οl	
					developed to ensure complian	ce.	
					By what date the systemic		
					changes will be completed;		
					Completion date: 1/3/23		
					Paper compliance is requested	a.	
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
	•	er and standpipe systems					
	-	ted, and maintained in IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	-	ting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAR	RKS information on					
	coverage for any r	non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,	, and NFPA 25					

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CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	JLTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/05/2022	
		155200	B. WI	NG			
	PROVIDER OR SUPPLIER		•	1564 S	ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD ID, IN 46989	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	facility failed to ens	vation and interview, the sure 1 of 1 sprinklers in the t, 2 of 3 sprinklers in the	K 03	353	K 353 Sprinkler System – Maintenance and Testing		01/03/2023
	were free of corrosis 5.2.1.1.1 sprinklers leakage; shall be from the comparishment of the comparishment of the comparishment of the comparishment of the corrosion (3) Physical the glass bulb heat a Loading (6) Paintin sprinkler manufacture.	of 10 sprinklers in the kitchen on. NFPA 25, 2011 edition, at shall not show signs of the of corrosion, foreign and physical damage; and shall correct orientation (e.g., or sidewall). Furthermore, at the that shows signs of any of the replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in the responsive element (5) gunless painted by the arer. This deficient practice and up to 40 residents in two tts.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  Corroded sprinklers in housekeeping closet, 200-hall spa and kitchen dish area are in process of being replaced by sprinkling company vendor.  Spare sprinkler heads (quick response) x 4 and sprinkler cabinet large enough to hold spares have been ordered and will be installed upon arrival.  Cabinet will be installed securely to wall upon arrival.			
	Director and the Ac between 10:30 a.m. sprinkler heads sho a) The sprinkler in b) The two sprinkler showers. c) The sprinkler about kitchen. Based on interview Maintenance Direct sprinkler heads sho #2) Based on obsert facility failed to ensemble the sprinkler heads sho	on with the Maintenance Iministrator on12/05/22 and 12:00 p.m., the following wed signs of corrosion: the housekeeping closet. It is in the 200-hall Spa by the over the dishwasher in the at the time of observation, the tor agreed the aforementioned wed signs of corrosion.			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;  All residents have the potential to be affected by the deficient practice.  Maintenance will conduct full audit of all sprinklers on premises to ensure that none showing signs of corrosion.  If any are noted to show signs of corrosion, they will be immediately replaced.	e e e ct a are	

spare sprinkler cabinet large enough to fit all spare sprinkler heads. NFPA 25, Standard for the

Inspection, Testing, and Maintenance of

What measures will be put into

place or what systemic changes

will be made to ensure that the

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CENTERS FO	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	LETED
		155200	B. WING		<u> </u>	12/05	/2022
NAME OF	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	NTER	I١	JPLAN	D, IN 46989		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	•	ID		provinces in an of connection (X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		ΆG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		rotection Systems, 2011			deficient practice does not rec	ıır.	
		1.1.4 states a supply of spare			· Maintenance/designee w		
		wer than six) shall be			round weekly to ensure all	111	
		remises so that any sprinklers			sprinkler heads are free from		
	-	ated or damaged in any way			corrosion.		
	_	placed. The sprinklers shall					
		-			· If any are noted to show		
		pes and temperature ratings			signs of corrosion, they will be		
	of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.				immediately replaced.		
						:II I	
					How the corrective action(s) w		
					monitored to ensure the defici		
					practice will not recur, what qu	•	
					assurance program will be put	into	
					place;		
					Ongoing compliance with	l	
					this corrective action will be		
	Findings include:				monitored via facility QAPI		
					program, with meetings being		
		on with the Maintenance			monthly, and is overseen by th	ne	
		nistrator on 12/05/22 at 10:51			Executive Director.		
	a.m., the following				<ul> <li>CQI tool identified Sprink</li> </ul>	ler	
		ler cabinet in the riser room			System Maintenance will be		
		gh to contain all sprinkler			completed weekly x 4 weeks,		
	_	lamage to the sprinkler heads.			monthly times 6 months, and		
		riser room was opened, the			quarterly thereafter until		
		nore sprinkler heads than spots			compliance is achieved.		
	available.				· If Threshold of 100% is n	ot	
		tler cabinet in the riser room			met, an action plan will be		
		cured to the wall, was loose			developed to ensure complian	ce.	
	and was hanging at				By what date the systemic		
	c) The facility conta	ained quick response sprinklers			changes will be completed;		
		ns and all halls. There were no			· Completion date: 1/3/23		
		e sprinklers in the spare			Paper compliance is requested	d.	
	sprinkler cabinet.						
	Based on interview	at the time of the					
	observations, the M	aintenance Director and					
	Administrator agree	ed the cabinet was not large					
	enough to contain a	ll spare sprinkler heads, the					
		net was not properly secured					
		pare quick response					
	1	_	1				1

						PRIN	TED:	12/27/2022
DEPARTMEN	T OF HEALTH AND HU	MAN SERVICES				FO	RM APP	ROVED
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0	938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVE	Y
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			LETED	
		155200	B. W.	B. WING			12/05/2022	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY NURSING CENTER  STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989								
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	COMF	PLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	D	ATE
	sprinklers.							
		the Maintenance Director						
	during the exit con  3.1-19(b)	rerence.						
K 0355	NEDA 101		ı		1		I	

K 0355

installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 15 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect 25 residents in one smoke compartment.

Portable Fire Extinguishers

Portable Fire Extinguishers

Portable fire extinguishers are selected,

Based on observations during a tour of the facility with the Maintenance Director on 12/05/22 between 10:30 a.m. and 11:30 a.m., the ABC portable fire extinguisher located in the dining hallway was blocked by a cart and a wheelchair. Also, the K-class portable fire extinguisher in the kitchen was blocked by a trash can. Based on interview at the time of observation, the Maintenance Director acknowledged the blocked fire extinguishers and removed the equipment.

The finding was reviewed with the Administrator and the Maintenance Director during the exit

K 355 Portable Fire **Extinguishers** 

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Items blocking fire extinguishers in kitchen and dining hall were immediately removed.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;

- All residents have the potential to be affected by the deficient practice.
- Audit of all other fire extinguishers was completed to ensure that no others were blocked. No issues found.

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Findings include:

SS=E

Bldg. 01

Event ID:

OTGC21

Facility ID: 000107

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01/03/2023

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-039

STREET ADDRESS, CITY, STATE, JP COD 1564 SUNIVERSITY BLVD UPLAND, IN 46989  ID PLAND, IN 46989  ID PROPRIET ADDRESS, CITY, STATE, JP COD 1564 SUNIVERSITY BLVD UPLAND, IN 46989  ID PROPRIET AND CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION  Conference.  3.1-19(b)  What measures will be put into place or what systemic changes will be monitored on ensure that the deficient practice does not recur; - Maintenance/designee will round daily to ensure all fire extinguishers remain unobstructed "All Staff in-service to be completed by 17/322 per ED on not obstructing fire extinguishers.  How the corrective action(s) will be monitored to ensure that duality assurance program will be put into place; - Ongoing compliance with this corrective action will be monitored via facility QAP1 program, with meetings being held monthly, and is overseen by the Executive Director Oct tool identified Portable Fire Extinguishers will be completed weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed: - Completed the systemic changes will be completed: - Completion date: 1/3/23 Paper compliance is requested.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155200		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/05/2022		
UNIVERSITY NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  Conference.  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/designee will round daily to ensure affirm settinguishers.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what qualify assurance program will be put into place;  - All Staff in-service to be completed by 1/3/23 per ED on not obstructing fire extinguishers.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what qualify assurance program will be put into place;  - Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.  - CQI tool identified Portable Fire Extinguishers will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.  - If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed:  - Completion date: 1/3/23 Paper Commitment of the program of the progr	NAME OF P	ROVIDER OR SUPPLIER						
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						place or what systemic chang will be made to ensure that the deficient practice does not reconstructed.  - Maintenance/designed round daily to ensure all fire extinguishers remain unobstructed.  - All Staff in-service to be completed by 1/3/23 per ED conot obstructing fire extinguished.  How the corrective action(s) we monitored to ensure the deficing practice will not recur, what que assurance program will be purplace;  - Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being monthly, and is overseen by the Executive Director.  - CQI tool identified Portal Fire Extinguishers will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.  - If Threshold of 100% is met, an action plan will be developed to ensure compliants by what date the systemic changes will be completed;  - Completion date: 1/3/23  Paper compliance is	es e cur; e will e on ers. vill be ent uality t into n held he ble	

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Event ID:

OTGC21 Facility ID: 000107

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
	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 12/05/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 0372 SS=F Bldg. 01	Barrie Subdivision of Bui Barrier Constructi 2012 EXISTING Smoke barriers sh 1/2-hour fire resis barriers shall be p atrium wall. Smok in duct penetration systems where ar is installed for smot to the smoke barr 19.3.7.3, 8.6.7.1(1 Describe any med system in REMAR Based on observation failed to ensure the passage of wires an barrier walls were p resistance of each s 8.5.6.2 requires per trays, conduits, pipe similar items to acc mechanical, plumbi	nall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.	K 0372	K 372 Subdivision of Building Spaces – Smoke Barriers  What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;  Three smoke barrier wall above drop ceiling and one attarea were repaired to meet	pe nts y the			

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floor/ceiling assembly constructed as a smoke

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requirements for smoke

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155200	B. WING			12/05/2022		
		<b>.</b>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEI	₹						
LINIIVED:	SITY NURSING CE	NTER		1564 S UNIVERSITY BLVD UPLAND, IN 46989				
UNIVER	SITT NORSING CE	INTER		UPLAND, IN 40969				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)			DATE	
		the ceiling membrane of the		penetrations.				
	roof/ceiling of a smoke barrier assembly, shall be							
	protected by a system or material capable of				How other residents having th			
	restricting the movement of smoke. This deficient			potential to be affected				
	practice affects all residents.				same deficient practice will be	;		
					identified and what corrective			
	Findings include:				action(s) will be taken;			
					· All residents have the			
		ons with the Maintenance			potential to be affected by the			
	Director and the Administrator on 12/05/22				deficient practice.			
	between 11:50 a.m. and a 12:05 p.m., the following				· All smoke barrier walls,			
	unsealed penetrations were discovered:				ceiling areas and attic were			
	a) Above the drop ceiling of the dining hallway				inspected for penetrations, no			
	smoke wall there was a 1½ inch unsealed hole				additional areas were identifie	d.		
	around wires.							
	b) Above the drop ceiling of the 100-hall smoke				What measures will be put int			
	wall there was a ½ inch unsealed hole around				place or what systemic chang			
	wires.				will be made to ensure that the			
	c) Above the drop ceiling of the 200-hall smoke wall there was a ½ inch unsealed hole around			deficient practice does not recur;  The Maintenance Director or				
	wires.	men unsealed note around						
		e 300-hall smoke wall there was			designee will conduct an audi identify penetrations in the fire			
		led hole around a sprinkler			walls, ceilings and attic weekl			
	pipe.	ned note around a sprinkler			4 weeks, then monthly for 3	y 101		
		at the time of observation, the			months and quarterly thereaft	er		
	Maintenance Director and Administrator agreed				until compliance is achieved.			
	the aforementioned smoke walls contained				and compliance is define to d.			
	unsealed penetrations and provided the				How the corrective action(s) w	vill be		
	measurements.				monitored to ensure the defici	, ,		
					practice will not recur, what quality			
	The finding was reviewed with the Administrator				assurance program will be put into			
	and the Maintenance Director during the exit				place;			
	conference.			· Ongoing compliance		ı		
				this corrective action will be				
	3.1-19(b)			monitored via facility QAPI				
					program, with meetings being	held		
					monthly, and is overseen by t			
					Executive Director.			
				· CQI tool identified Smok	е			
					Barrier will be completed wee	kly x		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155200	(X2) MULTII A. BUILDI B. WING		nstruction 01	(X3) DATE COMPL 12/05/	ETED		
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					4 weeks, monthly times 3 mon and quarterly thereafter until compliance is achieved.  If Threshold of 100% is n met, an action plan will be developed to ensure complian By what date the systemic changes will be completed;  Completion date: 1/3/23 Paper compliance is requested.	ot ce.			

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