STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00418930. Complaint IN00418930- Federal deficiencies related to the allegations are cited at F689. Survey dates: November 13, 14, 15, 16, 17, and 20, 2023. Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 6 Medicaid: 52 Other: 7 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 27, 2023.	F 0000	University Nursing Center submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests paper compliance in lieu of a post survey review on or after December 8th,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			2023.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure light cords were within reach for 2 of 6 residents interviewed for accommodation of needs. (Residents 58 and 166) Finding includes: During an observation on 11/14/23 at 4:10 p.m., Resident 58 and Resident 166 lacked reachable cords to their overbed lights. The overhead lights were turned on by utilizing a chain approximately one half the width of a piece of loose-leaf paper. During an interview, on 11/15/23 at 2:30 p.m., Resident 166's representative indicated the resident was unable to reach the light cord to turn on the light as the cord was too short. He could turn it on for her while he was there. During an interview, on 11/16/23 at 3:49 p.m., Resident 58 indicated she could not reach the light cord. She asked the staff to turn the light on and off. During an interview, on 11/17/23 at 11:33 a.m., the Maintenance Director indicated he had not noticed the light cord strings were missing.	F 0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Light cords for resident 58 and 166 have been replaced. 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 affected by the same deficient practice. Maintenance Director completed facility audit of light cords by 12/4/23 to ensure no other residents affected. All staff in-service per ED/Designee by 12/7/23 on Resident Rights Policy including accommodation of needs and completing Maintenance Work Orders. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	12/08/2023

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	A review of Resident 58's clinical record, on 11/20/23 at 2:53 p.m., indicated the resident was cognitively intact and independent with ambulation and transfers. She required partial/moderate assistance moving from lying to sitting on the side of the bed. A review of Resident 116's clinical record, on 11/20/23 at 3:06 p.m., indicated, in the Admission Observation on 11/11/23, the resident was alert and oriented to person, time, place, and situation. She had weakness and limitation to her range of motion to her left upper extremity including her middle finger, ring finger, pinky, thumb, and index finger. Her right side did not have limitations or weakness. A current facility document titled "Resident Rights," dated 10/23 and provided on 11/13/23 with the entrance conference papers in the resident's admission packet by the Administrator, indicated " ...The resident has a right to care in an environment that promotes maintenance or enhancement of each resident's quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely ...." A current facility policy, provided by the Maintenance Director on 11/16/23 at 3:25 p.m., dated 11/15, titled "Maintenance Work Orders," indicated "...Our Community provides routine maintenance for tenants and is responsible for the overall management of the physical plant ...." 3.1-3(v)(1)		All staff in-service per ED/Designee by 12/7/23 on Resident Rights Policy including accommodation of needs and completing Maintenance Work Orders. Assigned Care Companion will complete daily room environment checks, to include light cords, completing Work Orders if indicated. Work Orders will be reviewed daily in Morning Meeting with the Executive Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality 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. Accommodation CQI tool 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; Date of Completion: 12/8/23.	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews and record review, facility failed to ensure a dependent resident who required two person assist during transfers was transferred according to their care plan for of 1 of 5 residents reviewed for accidents (Resident 21). Findings Include: During an interview, on 11/14/23 at 9:24 a.m., Resident 21 indicated CNA 5 transferred her alone and caused an injury. Her injury had improved, but continued with soreness. She did not let this CNA transfer her in any type of lift since the incident. The clinical record for Resident 21 was reviewed on 11/14/23 at 3:08 p.m. The diagnoses included, but were not limited to, pain in joints, repeated falls, chronic diastolic heart failure, muscle weakness, age related physical debility, and cognitive communication deficit. Current physician orders included Hoyer (mechanical) lift with two person assist, dated 5/31/23. A quarterly Minimum Data Set (MDS) assessment, dated 8/29/23, indicated the resident required extensive assistance with bed mobility, transfer, dressing, shower, eating, sit to stand,	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 21 is being transferred via hoyer lift with 2 staff. Resident currently participating in Physical Therapy. CNA 5 has been reeducated on the hoyer lift and stand up lift utilizing to staff members for resident transfers. 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 transferred via mechanical lift have the potential to be affected. All nursing staff in-serviced on Fall Management Policy and Hoyer/Stand up lift practices utilizing 2 staff with transfers per DNS/Designee by 12/7/23. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff in-serviced on	12/08/2023

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	chair to bed, and toilet transfer. She was cognitively intact. A care plan initiated 8/16/17, revealed she was at an increased risk for falls due to age. Interventions included Hoyer lift of two person assistance with transfers and therapy screens for appropriate transfer methods. A progress note, dated 10/2/23 at 3:32 p.m., indicated Resident 21 was transferred from a shower chair to a wheelchair during a one person transfer with a stand up lift and slid out of lift onto the floor, hitting the back of her head. A hematoma was noted to the back of her head after the incident, along with complaints of headache, neck pain, and increased confusion. She was sent to the emergency room for evaluation. A progress note, dated 10/2/23 at 11:55 p.m., indicated she returned from the emergency room where CT of head/cervical spine showed no signs of fracture and no internal bleeding. An X-ray of her left hip showed no signs of fracture. No evidence of a urinary tract infection was found. No new areas of concern were noted after the skin assessment. During an interview, on 11/15/23 at 9:33 a.m., the DON and Nurse Consultant (NC) indicated all staff members had completed job specific training including lift transfers. The DON provided a copy of CNA 5's mechanical stand lift skills competency form, last reviewed date was 6/2023, noting mechanical lifts required two staff members. During an interview, on 11/15/23 at 1:44 p.m., CNA 5 indicated the incident occurred due to her neglect in transferring resident alone. The CNA took full responsibility for the incident and not		Fall Management Policy and Hoyer/Stand up lift practices utilizing 2 staff with transfers per DNS/Designee by 12/7/23. Mechanical Lift skills validation completed by all nursing staff by 12/7/23. All new nursing staff will have Mechanical Lift skills validation completed upon hire. Transfer observations to be completed by assigned Nurse Manager Nurse manager/designee will round and observe mechanical lift transfers are conducted per resident plan of care and per protocol. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality 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. Mechanical Transfer CQI tool 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;	

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	following residents required orders of two person assistance with transfers. There were cultural issues where you were expected to cut corners and there was difficulty getting help from other staff members. The CNA still provided care to the resident, with the exception of transferring her in any type of lift. During an interview, on 11/15/23 at 4:06 p.m., CNA 6 indicated they follow caresheets for residents' care. They used a buddy system when residents required two staff members for care and transfers. A review of Point of Care (POC) charting, on 11/17/23 at 3:08 p.m., indicated staff members had documented the resident as a one person transfer. Five staff members, between 10/1/23 and 11/16/23, documented she required one person assistance with transfers using the Hoyer lift. During an interview, on 11/17/23 at 3:20 p.m., DON and NC indicated they needed to perform an inservice with staff members on accurate charting. A current facility policy, titled "FALL MANAGEMENT POLICY," last revised on 8/2022 and provided by the DON on 11/20/23 at 2:25 p.m., indicated "...Policy It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...Procedure Fall risk...3. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. Care plan including interventions and fall risks will be reviewed at least quarterly...6. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...."		Date of Completion: 12/8/23.	

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	This Federal tag relates to complaint IN00418930. 3.1-45(a)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a safe and homelike environment for 5 of 17 resident rooms reviewed for environment when black television cable cords were strung haphazardly on the walls of the rooms (Rooms 101, 103, 104, 106, and 107) and the chair rail and baseboards were damaged for 1 of 17 rooms. (Room 106) Findings include: During a random observation, on 11/14/23 at 4:10 p.m., resident rooms 101, 103, 104, 106, and 107 had black cable cords strung from the cable outlet along the walls with gaps between the wall and the cable cord. Room 106 had a damaged chair rail above the head of the bed near the window. The chair rail was cracked and jutting out from the wall slightly with sharp edges. The baseboard below the damaged chair rail was pulling away from the wall in two places. During on observation on 11/15/23 at 2:30 p.m., Room 107 had a black cable television cord strung with gapes between the wall and the cord from the cable outlet along the wall, above the door, to the television on the wall by the door. A resident representative interview, at the time of the observation, indicated he did not know why the cords were there. He had tried to turn on the	F 0921	**F 921** **Safe/Functional/Sanitary/Comfortable Environment** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Cable Cords have been secured and present in a homelike manner in rooms 101, 103, 104, 106 and 107. Chair rails and baseboards have been replaced in rooms 1 and 17. 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 that reside in the facility have the potential to be affected. Maintenance completed facility audit of cable cords, base boards and chair rails by 12/4/23 to ensure no other residents were affected. All staff in-service per ED/Designee by 12/7/23 on	12/08/2023

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	television, but it did not work. During an interview, on 11/15/23 at 3:06 p.m., the Maintenance Director indicated his practice was to tack the black television cable cords to the wall. He had not been told how to properly conceal them. During an interview, on 11/15/23 at 3:25 p.m., the Maintenance Director indicated he had spoken with his corporate manager. He should have run the cables through the ceiling and dropped them where they needed to be. During an observation, on 11/16/23 at 3:49 p.m., the chair rail in Room 106 remained broken with sharp edges. During an interview, at the time of the observation, CNA 51 indicated she had not noticed the broken chair rail above the headboard of the bed by the window in Room 106. She touched the trim and indicated it was sharp. During an observation, on 11/16/23 at 3:49 p.m., the black television cable cords remained visible and strung haphazardly in Rooms 101, 103, 104, 106, and 107. During an observation, on 11/17/23 at 9:41 a.m., in Room 106, the baseboard was pulled away from the wall directly below the chair rail behind the bed near the window in two places. The area near the side near the window was approximately the half the size of a loose-leaf paper pulled away from the wall approximately the length of three quarters. The area nearer to the door was approximately the length of three quarters and pulled away from the wall approximated the length of a quarter. The bed frame was resting on the pulled away areas.		Resident Rights Policy including accommodation of needs and completing Maintenance Work Orders. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-service per ED/Designee by 12/7/23 on Resident Rights Policy including accommodation of needs and completing Maintenance Work Orders. Assigned Care Companion will complete daily room environment checks, completing Work Orders if indicated. Work Orders will be reviewed daily in Morning Meeting with the Executive Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality 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. Environment CQI tool 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	

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	During an interview, on 11/17/23 at 11:33 a.m., the Maintenance Director indicated he had noticed the baseboards pulling away from the wall yesterday, but had not had time to repair them yet. During an observation, on 11/20/23 at 2:33 p.m., Room 101 continued to have the black cable cords hanging on the wall on both sides of the room with gaping between the wall and the cord approximately as long as the width of a loose-leaf paper in some areas. The cord went over the door. During an observation, on 11/20/23 at 2:35 p.m., Room 103 continued to have black cable cords strung haphazardly around the walls. One cord went over the door then hung down the wall un-tacked with the end connected to nothing. During an observation, on 11/20/23 at 2:38 p.m., Room 106 continued to have black cable cords strung about the room along the wall. A cord going over the door was not tacked down along the wall and went behind the dresser. During an observation, on 11/20/23 at 2:43 p.m., Room 107 continued to have black cable cords strung along wall with gaps between wall and cord. The cord hung down just above the door and connected to a television beside the door. A current facility document titled "Resident Rights," dated 10/23 and provided on 11/13/23 by the Administrator with the entrance conference papers in the resident admission packet, indicated " ...The resident has a right to care in an environment that promotes maintenance or enhancement of each resident's quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for		developed to ensure compliance. By what date the systemic changes will be completed; Date of Completion: 12/8/23.	

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	daily living safely ...." A current facility policy, provided by the Maintenance Director on 11/16/23 at 3:25 p.m., dated 11/15 and titled "Maintenance Work Orders," indicated "...Our Community provides routine maintenance for tenants and is responsible for the overall management of the physical plant ...." A current facility policy, provided by the Administrator on 11/20/23 at 2:57 p.m., dated 11/15 and titled "Preventative Maintenance Plan," indicated "...The Community shall provide preventative maintenance for the Community ...." 3.1-19(f)(5)			