STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155200	A. BUILDING -- B. WING	12/11/2023

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/11/23 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 64 at the time of this survey. Quality Review completed on 12/12/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/11/23 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	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin M. Beard	Executive Director	12/22/2023

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 64 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility had a storage shed of maintenance supplies that was not sprinklered. Quality Review completed on 12/12/23		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 24th, 2023.	
K 0211 SS=D Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to ensure 1 of 1 egress doors from the MDS office met the clear width according to LSC 7.2.1.2.3.2 which states door openings in means of egress shall be not less than 32 in. (810 mm) in clear width. This deficient practice could affect 2 residents in the MDS office. Findings include: Based on observation with the Maintenance Director on 12/11/23 at 10:25 a.m., the MDS office door would only half open due to a damaged self-closing device. This condition reduces the clear width of 32 inches by half. Based on interview at the time of observation, the Maintenance Director agreed the MDS office door would not fully open to the required width of 32 inches. The finding was reviewed with the Maintenance Director and the administrator during the exit conference. 3.1-19(b)	K 0211	**K 211 Means of Egress-General** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The damaged self-closing device has been replaced. The MDS office door now opens to a width of 32 inches. 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; Any resident in or around the area in question could be affected by the same deficient practice. Maintenance Director completed facility audit of all office doors to ensure 100% of doors opened 32 inches All staff in-service per ED/Designee by 12/24/23 on all resident doors must open to 32 inches and to complete a maintenance work order if they do not 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 12/24/23 on all resident doors must open to 32 inches and to complete a maintenance work order if they do not. Maintenance	12/24/2023

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			Director/designee to check resident doors daily 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. Means of egress 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: 12/24/23.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, 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 inspect 1 of 1 portable fire extinguishers in the Beauty shop each month. NFPA 10,	K 0355	**K 355 Portable Fire Extinguishers**	12/24/2023

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	Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 3 residents in the Beauty shop. Findings include: Based on observation during a tour of the facility		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The fire extinguisher in the beauty shop has been inspected and documented. 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; Any resident in or around the area in question could be affected by the same deficient practice. The ED in-serviced the Director of Maintenance on the monthly inspections and documenting the findings of portable fire extinguishers. All other portable fire extinguishers were inspected by the Maintenance director to ensure monthly inspections were completed What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The ED in-serviced the Director of Maintenance on the monthly inspections and documenting the findings of portable fire extinguishers. ED/designee will round and audit the documented inspections of all portable fire extinguishers How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality	

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	with the Maintenance Director on 12/11/23 at 10:42 a.m., the monthly inspection tag on the ABC fire extinguisher located in the beauty shop lacked documentation of a monthly inspections for September, October, and November of 2023. Based on interview at the time of observation, the Maintenance Director confirmed the extinguisher located in the beauty shop were missing three monthly visual inspections. The finding was reviewed with the Maintenance Director and the administrator during the exit conference. 3.1-19(b)		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. Portable fire extinguisher 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: 12/24/23.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 1 corridor therapy doors and 1 of 3 corridor kitchen doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 35 residents in the dining room. Findings include: Based on observation with the Maintenance Director on 12/11/23 from 10:35 a.m. to 10:40 a.m., the therapy corridor door was propped open with dumbbells and the kitchen corridor door in the service hall was propped open with a door wedge.	K 0363	**K 363 Corridor-Doors** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Both corridor doors kitchen and therapy were immediately closed. 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; Any resident in or around the	12/24/2023

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	Based on interview at the time of observation, the Maintenance Director agreed the aforementioned corridor doors were propped open impeding the doors from closing. The finding was reviewed with the Maintenance Director and the administrator during the exit conference. 3.1-19(b)		area in question could be affected by the same deficient practice. The ED/designee in-serviced all members of the therapy department and culinary department on ensuring doors are kept closed. All corridor doors were inspected to ensure doors were not propped open by the maintenance director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The ED/designee in-serviced all members of the therapy department and culinary department on ensuring doors are kept closed. Director of Maintenance/designees will round facility daily to ensure doors are not propped open. If doors are propped open, they will be immediately closed and staff will be in-serviced. 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. Corridor-doors CQI tool will be completed weekly x 4 weeks,	

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			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: 12/24/23.	