STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 01 B. WING	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/11/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 02/06/24 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 At this PSR survey, University Nursing Center was found not in compliance with Requirements for Participation in 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 02/08/24	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Benson	Executive Director	02/20/2024

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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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 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			

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	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 1 activity office 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 one smoke compartment. Findings include: Based on observation with the Maintenance Director on 02/06/24 from at 11:45 a.m., the therapy corridor door was propped open with dumbbells and the activity office door in the service hall was propped open with a door wedge. 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. This deficiency was cited on 12/11/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0363	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	02/16/2024

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			allegation and requests paper compliance in lieu of a post survey review on or after February 16th, 2024. 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 for activities 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 area in question could be affected by the same deficient practice. The ED/designee in-serviced all members of the therapy	

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			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 activity office door had an electromagnetic lock system installed on 2/16/24 that releases and shuts when fire alarm triggers 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.	

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			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, 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.	

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			By what date the systemic changes will be completed; Date of Completion: 2/16/24.	