PRINTED: 03/06/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		155200	B. WING			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, S 1564 S UNIVERSITY BLVD UPLAND, IN 46989		02/23/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F (000		
	This visit was for the IN00452449 and IN00	Investigation of Complaints 0452401.				
	Complaint IN0045244 to the allegations are	49 - No deficiencies related cited.				
	Complaint IN0045240 deficiencies related to F684 and F686.	01 - Federal/state o the allegations are cited at				
	Survey dates: Februa	ary 21, 24, and 25, 2025				
	Facility number: 0001 Provider number: 155 AIM number: 100290	5200				
	Census Bed Type: SNF/NF: 65 Total: 65					
	Census Payor Type: Medicare: 3 Medicaid: 54 Other: 8 Total: 65					
	These deficiencies re accordance with 410	flect State Findings cited in IAC 16.2-3.1.				
F 684 SS=D	, · ,	eted March 5, 2025.	F	584		
	applies to all treatme	are ndamental principle that nt and care provided to ed on the comprehensive				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	_	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	١ , ,	(X3) DATE SURVEY COMPLETED	
		155200	B. WING			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	,	02/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	that residents receive accordance with prof practice, the comprel care plan, and the re This REQUIREMENT by: Based on record rev failed to identify and care of a surgical wo reviewed for wound of deficient practice was 2025, prior to the statherefore past nonco. Findings include: Resident B's closed on 2/25/25 at 1:26 p. fracture of neck of rigencounter for closed acute posthemorrhag with other behavioral. The resident admitter following surgical rep (on 12/24/24) and ob (urinary obstruction). A care plan, dated 12 was a new admission implementation of seemotional, and psychassistance with activichronic obstructive pweakness, right femulation.	dent, the facility must ensure extreatment and care in ressional standards of thensive person-centered sidents' choices. T is not met as evidenced riew and interview, the facility implement interventions for und for 1 of 3 resident care. (Resident B) The scorrected on February 10, rt of the survey, and was impliance. Clinical record was reviewed in Diagnoses included the femur, subsequent fracture with routine healing, gic anemia, and dementia disturbance. If to the facility on 12/30/24 their of the right femur fracture instructive and reflux uropathy 2/31/24, indicated Resident B in to the facility and required rices to promote physical, nosocial well-being including titles of daily living related to ulmonary disease, ar fracture with immobilizer. dan intervention to provide	F 68	Past noncompliance: no plan correction required.	of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	C	X3) DATE SURVEY COMPLETED
		155200	B. WING _			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			32/23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATI	(X5) COMPLETION DATE
F 684	was at risk for skin brincontinence and righ Interventions included condition weekly and A care plan, dated 12 resident was at risk for history of falls, advantethering equipment, cognition, and right less acreplan, dated 1/6 had impaired skin (suincluded assessing with documenting measur Notify MD of change or signs of infection. Observe for sings of idrainage, malodorous size/depth of wound. Review of the 12/30/2 indicated Resident B the right thigh and a rassessment of the sk was not completed. Review of a progress 2:12 a.m., indicated Feright leg in place. assessed. Review of the progrest through 1/3/2025 indiwas assessed, but th wound was not removed.	d'31/24, indicated Resident B eakdown due to weakness, it leg immobilizer. It assess and document skin as needed. d'31/24, indicated the profession of falls due to weakness, ced age, medications, incontinence, impaired in its grid immobilizer. d'35/25, indicated the resident impaired immobilizer. d'25/25, indicated the resident impaired immobilizer. d'26/25, indicated the resident impaired immobilizer. d'27/26/26/26/26/26/26/26/26/26/26/26/26/26/	F	584		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		155200	B. WING _			C 02/25/2025
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F 684	Continued From pag	e 3	F 6	84		
	Nurse Practitioner (Na.m., indicated a dre surgical area was in place until the reside The dressing was not the dressing was not Review of a progress p.m., indicated the reof two people for all atolerated the use of a The most recent adm (MDS) assessment, Resident B was at rishad impairment to or extremity. The reside assistance for eating dressing, roll left to rassistance for person to sitting, picking up for toilet/shower tranapplication and remoshowers, and toilet hof bowel and admitted An orthopedic surger 1/14/25, indicated Resident B's physicial Administration Recondadministration Recondadministration Recondadministration Recondadministration surgical sitesident's su	assing to the right hip/thigh place and was to be left in int was seen by the surgeon. It removed. In note, dated 1/3/25 at 2:30 esident required assistance activities of daily living and assistive devices. In ission Minimum Data Set dated 1/6/25, indicated sk for pressure injuries and the side on the lower ent required partial/moderate in, oral hygiene, upper body ight. Substantial/max that hygiene, sit to stand, lying an object. He was dependent effer, sit- to-stand, footwear eval, dressing lower body, ygiene. He was incontinent and with an indwelling catheter. In progress note, dated esident B's right leg surgical removed and steri-strips were entered in orders, Medication rds (MAR), and Treatment rds (TAR) for 12/30/24 end orders for care of the ite.				
	Resident B transferre facility on 2/17/25 pe	ed to another long-term care r their choice.				

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		155200	B. WING			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		02/23/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 4	F 68	84		
	a.m., the orthopedic the surgeon's office indicated the dressin surgical site should following the surger. During an interview 1 indicated Residen a right leg immobilize surgical wound to than immobilizer nor fin place at admissio call to get clarification Residents were to hompleted and docu LPN 1 was unable to completed for Residents.	rview on 2/24/25 at 10:25 surgeon's nurse indicated note from the hospital ng to Resident B's right leg have been changed five days y. on 2/24/25 at 11:13 a.m., LPN t B admitted to the facility with er brace in place and a e right thigh. No orders for or surgical wound care were in to the facility. LPN 1 did not on for the missing orders. ave weekly skin assessments imented in the clinical record. to locate skin assessments ent B in the clinical record to the facility on 12/30/24.				
	DON indicated, during assessment of Resignation of	on 2/24/25 at 1:52 p.m., the tioner (NP) indicated I not want anyone to remove until the first follow-up visit. e authority to write orders in lity should have gotten a				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	, 32.23.23	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 684	was provided by the I The policy indicated to "Policy: It is the policic Communities to provide documentation of the of each resident admit facility and to assist the adjusting to the facility will be followed for all respite care Initial nursing assess Observation 5. A thorough head to skin) must be done at in skin integrity must assessment. The physpecific treatment ord Physician orders: Verification of orders: 1. The admitting nursiphysician to verify all	y, dated 7/24, titled dmission Policy Procedure" DON on 2/25/25 at 1:57 p.m. he following: y of American Senior de baseline and accurate mental, physical condition litted or readmitted to the ne resident and family with y. Admission procedures new admissions including ment: Admission o toe assessment (including admission. Any altercations be identified on nursing sician must be notified for lers	F 68	,		
	provided by the DON The policy indicated t " Resident Assess Weekly skin and vital observation (All new s to the wound nurse w completed)" Review of Resident B	on 2/25/25 at 1:57 p.m. he following: ments Completed Weekly signs assessment skin areas must be reported				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		155200	B. WING				25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER		1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 564 S UNIVERSITY BLVD IPLAND, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	DON and the Corpora facility should have no related to the surgical immobilizer. This deficient practice 10, 2025 after the facility plant that included the assessment of all resin-servicing education completion of skin as of or obtaining treatm monitoring by Quality Performance Improve This citation relates to 3.1-(37)(a)	n 2/24/25 at 2:07 p.m., the ate Consultant indicated the oted the lack of orders I wound and the leg e was corrected by February illity implemented a systemic following actions: idents for wounds, in to staff related to sessments and clarification ent orders, and ongoing Assurance and ement (QAPI) activities. Complaint IN00452401.		684			
F 686 SS=G	S483.25(b)(1) Skin Integ §483.25(b)(1) Pressure Based on the compreresident, the facility m (i) A resident receives professional standard pressure ulcers and culcers unless the indidemonstrates that the (ii) A resident with prenecessary treatment with professional star promote healing, prevnew ulcers from deve	rity re ulcers. hensive assessment of a nust ensure that- s care, consistent with ls of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent	F	686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155200	B. WING			C // 25/2025
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	1 02	12012020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	failed to implement so pressure injury, failed medical device that impairment, and failed interventions to prevoke residents reviewed fare B) This deficient pradeveloping an unstar right knee requiring amputation of the low was corrected on Festart of the survey, an oncompliance. Findings include: Resident B's closed on 2/25/25 at 1:26 p fracture of neck of rigencounter for closed acute posthemorrha with other behaviora. The resident admitter following surgical regand obstructive and obstructive and obstruction). A care plan, dated 1 was at risk for skin be incontinence and rig Interventions include condition weekly and A care plan, dated 1 resident was at risk history of falls, advantage of the present the prese	and record review, the facility skin assessments to identify d to obtain orders for a increased the risk of skin ed to develop and implement tent pressure injury for 1 of 3 or pressure injury. (Resident ctice resulted in Resident B geable pressure injury to the hospitalization and eventual wer leg. The deficient practice bruary 10, 2025, prior to the and was therefore past clinical record was reviewed and was therefore past clinical record was reviewed fracture with routine healing, gic anemia, and dementia I fracture with routine healing, gic anemia, and dementia I disturbance. d to the facility on 12/30/24 or of the right femur fracture reflux uropathy (urinary) 2/31/24, indicated Resident B or eakdown due to weakness, the leg immobilizer. ded assess and document skin	F 686	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	 	1 02/20/20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	cognition, and right leads to cognition, and right leads a lead of the right thigh and a leadsessment of the sk was not completed. Review of a progress 2:12 a.m., indicated the right leg in place. assessed. Review of a Skin and Nurse Practitioner, doindicated the resident deep tissue injury (into for persistent non-blar purple discoloration cosoft tissue) and skin the left upper forearm. A hip/thigh surgical are left in place until residurgeon. The care plan lacked healing of the right healing of the right healing of the prevention of pressure. Review of a progress p.m., indicated the resident depression of the legal of the right healing healin	eg immobilizer. 24 admission assessment presented with a dressing to right leg immobilizer. An in under the immobilizer note, dated 12/31/24 at Resident B had a brace to The resident's skin was not Wound note by the Wound ated 1/3/25 at 11:38 a.m., at admitted with a right heel fact skin with localized area inchable deep red, maroon, flue to damage of underlying ears to the right elbow and adressing to the right a was in place and was to be dent was seen by the interventions to support seel deep tissue injury. interventions specific to the end in the properties of daily living and	F 6	86			
		ission Minimum Data Set dated 1/6/25, indicated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		155200	B. WING _			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, Z 1564 S UNIVERSITY BLVD UPLAND, IN 46989	IP CODE	02/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIAT	
F 686	had impairment to on extremity. The reside assistance for eating dressing, roll left to ri assistance for persor to sitting, picking up a for toilet/shower trans application and remo showers, and toilet hy of bowel and admitte. An orthopedic surged 1/14/25, indicated a rwas identified on the may have had full-thi petrolatum (for wound to the knee wound ar plan of care. The wowound care provider. There pressure injury to the was aimed at healing. An order written by the 1/14/25 during a followound care to the opwas to start on 1/17/2. An "event" progress indicated an open are centimeters (cm) long knee was identified on Resident B's physicia Administration Recor Administration Recor Administration Recor	k for pressure injuries and e side on the lower nt required partial/moderate oral hygiene, upper body ght. Substantial/max hal hygiene, sit to stand, lying an object. He was dependent offer, sit- to-stand, footwear eval, dressing lower body, bygiene. He was incontinent downth an indwelling catheter. In progress note, dated hecrotic (dead tissue) wound resident's right knee, which cokness involvement. And care) dressing was applied had its use was added to the und required monitoring by a handsorbent dressing to be managed by the wound was concern about the right knee and treatment had been area on the right knee en area on the right knee en area on the right knee en area on the right knee of the particular of the right knee en area on	F	686		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155200	B. WING _			C 02/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1564 S UNIVERSITY BLVD UPLAND, IN 46989		5212012020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	until 1/17/25. Resident B transferre facility on 2/17/25 per A wound managemer long term care facility presented with an unskin and tissue loss ir damage within the uld because the wound beschar) pressure injuring assuring 2.0 cm lon. The width could not be wound was covered by yellow, tan, gray, greemoist, can be soft, strexture) and eschar (of that is hard or soft in brown, or tan in color. An orthopedic hospita 1/29/25, indicated Re 1/28/25 with a necrotic The wound was ident follow-up appointment developed purulent dibone and hardware (for replacement). The residence above-the-knee amputation in the surgeon's office in another hospital follow provided) did not incluimmobilizer brace to be surgeon's received.	d to another long-term care their choice. In note from the receiving indicated Resident B stageable (full-thickness in which the extent of tissue cer cannot be confirmed ed is obscured by slough or my to the right knee, in gwith a depth of 0.5 cm. in e accurately measured. The with slough (non-viable en or brown tissue; usually ingy and mucinous in dead or devitalized tissue exture; usually black, in and may appear scab-like). In consultation note, dated is ident B presented on it is consultation with the extent of the consultation on the right knee. If it is during an orthopedic it on 1/14/2025 and had rainage and then visible from previous knee is ident underwent right legistation on 1/29/25. In the consultation of the provided in the consultation on 1/29/25 at 10:25 is in the consultation of the provided in the consultation of the provided in t	F6	886		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		155200	B. WING			C 0 2/25/2025
	ROVIDER OR SUPPLIER TY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	a right leg immobilizer for an immobilizer we the facility. LPN 1 did for the missing order to Resident B's right weekly skin assessm documented in the clunable to locate skin Resident B in the clinadmission to the facility admission to the facility admission to the facility with a rimmobilizer needed to the facility with a rimmobilizer. During an interview of DON indicated Resid an order for the use of The DON thought shout had no document have confused two singular the lack of orders for clarification should had documented. During an interview wat 1:00 p.m., CNA 3 in brace on his right leg during his stay. It has sleep and for shower	B admitted to the facility with a brace in place. No orders are in place at admission to a not call to get clarification for the immobilizer in place leg. Residents were to have ents completed and inical record. LPN 1 was assessments completed for inical record since his ity on 12/30/24. The cord in the resident admitted ght leg immobilizer. The obe adjusted on occasion of place. PT 2 was not sure ission orders included	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		02/23/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE		
F 686	Continued From page 12 and did not notice any new skin impairments. A		F 6	86			
	shower sheet, dated not find any new skir	1/12/25, indicated CNA 3 did impairments.					
	Wound Nurse Practif surgeons usually did a surgical dressing u She did not have the	not want anyone to remove ntil the first follow-up visit. authority to write orders in ity should have gotten a					
	was provided by the The policy indicated "Policy: It is the polic Communities to provide documentation of the of each resident admits adjusting to the facility and to assist adjusting to the facility will be followed for all respite care Initial nursing assess Observation 5. A thorough head skin) must be done as in skin integrity must assessment. The physician orders: Verification of orders 1. The admitting nur	dmission Policy Procedure" DON on 2/25/25 at 1:57 p.m. the following: by of American Senior ide baseline and accurate a mental, physical condition witted or readmitted to the he resident and family with by. Admission procedures I new admissions including ament: Admission to toe assessment (including to tadmission. Any altercations be identified on nursing ysician must be notified for ders					
		ed 7/24, titled delines for Nursing: was I on 2/25/25 at 1:57 p.m.					

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F 686	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	586			