

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER University Heights Health and Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E County Line Rd S Indianapolis, IN 46227	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>35099</p> <p>Based on observation, interview, and record review, the facility failed to ensure self-medication administration assessments were completed for 4 of 4 residents observed with medications at bedside. (Resident 53, Resident 1, Resident 105, Resident 39)</p> <p>Findings Include:</p> <p>1. On 8/20/24 at 10:32 a.m., observed Resident 53 was sitting up in bed; no staff were observed to be in the room or in hallway. Resident 53 had an overbed table with the following observed to be sitting on top of the table; one clear plastic medication cup containing two small white tablets and one and a half large tablets.</p> <p>On 8/21/24 at 8:33 a.m., Resident 53 was observed sitting up in bed eating. A small plastic medication cup was observed sitting on the overbed table containing three small white tablets, two large white tablets broken in half, one orange tablet, and one peach colored tablet.</p> <p>On 8/21/24 at 8:40 a.m., Resident 53's clinical record was reviewed. The clinical record lacked a self-medication administration assessment.</p> <p>On 8/22/24 at 1:18 p.m., the Director of Nursing indicated that there was not a self-medication administration assessment for Resident 53.</p> <p>2. On 8/21/24 at 8:56 a.m., Resident 1 was observed sitting up in bed holding a small plastic medication cup with a blue and white capsule.</p> <p>On 8/21/24 at 9:00 a.m., Resident 1's clinical record was reviewed. The clinical record lacked a self-medication administration assessment.</p> <p>On 8/22/24 at 1:18 p.m., the Director of Nursing indicated that there was not a self- medication administration assessment for Resident 1.</p> <p>3. On 8/21/24 at 8:59 a.m., Resident 105 was observed lying in bed. On the overbed table there was a small plastic medication cup containing three small white tablets, one large white tablet, one oval yellow tablet, one cream tablet, and one white capsule.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/21/24 at 9:09 a.m., Resident 105's clinical record was reviewed. The clinical record lacked a self-medication administration assessment.</p> <p>On 8/22/24 at 1:18 p.m., The Director of Nursing indicated that there was not a self-medication administration assessment for Resident 105.</p> <p>During an interview on 8/22/24 at 1:05 p.m., Unit Manager 2 indicated nurses should stay with residents to make sure medications were taken. Unit Manager 2 indicated if the resident did not take the medications then the nurse should take the medications when the nurse left the room.</p> <p>During an interview on 8/22/24 at 1:18 p.m., the Director of Nursing indicated nurses should not leave medications in resident rooms.</p> <p>38466</p> <p>4. On 8/23/24 at 2:52 p.m., Resident 39's clinical record was reviewed. The quarterly Minimum Data Set assessment, dated 6/19/24, indicated Resident 39 was cognitively intact.</p> <p>Resident 39's clinical record lacked a self-medication administration assessment.</p> <p>On 8/26/24 at 8:30 a.m., Resident 39 was observed in her room sitting in the wheelchair. The over the bed table was positioned in front of the resident who was eating her breakfast meal. The table was observed to have a small clear plastic medicine cup that contained multiple large and small white unidentified medication pills and tablets. During an interview at that time, Resident 39 indicated the nurse dropped off the medication as the resident liked to take her pills after she had eaten. Resident 39 indicated sometimes staff left the medications in her room and had not watched her take the medications.</p> <p>During an interview on 8/26/24 at 8:30 a.m., Unit Manager 4 indicated Resident 39 had not been assessed to self-administer her medications. Staff were to administer Resident 39's medications and ensure all medications were taken before leaving the resident's room. Medications were not to be left at the resident's bedside.</p> <p>On 8/26/24 at 1:30 p.m., the Director of Nursing provided a copy of the Administering Medications policy, dated December 2012, and indicated it was the current policy in use by the facility. A review of the policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so .</p> <p>3.1-11(a)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36746</p> <p>Based on interview and record review, the facility failed to provide a written notice to a resident prior to getting a new roommate. (Resident 25)</p> <p>Findings include:</p> <p>On 8/22/24 at 8:45 a.m., Resident 25 was observed in her wheelchair in the hall way. The resident was moving around in her chair and fidgeting with her hands. She indicated she was very nervous. She indicated the facility had recently given her a new roommate. The new roommate was receiving hospice services and was actively dying. The resident indicated she was unaware that she was going to get a new roommate and was surprised. The new roommate passed away after seven days. I had to sit and watch her die for seven days. Resident 25 indicated she was not informed about getting new roommate until the day before the new roommate was admitted and that was only because they were making sure the room was clean. The resident did not receive a written notice about a new roommate.</p> <p>On 8/23/24 at 9:33 a.m., the clinical record of Resident 25 was reviewed. The diagnosis included, but was not limited to, depression.</p> <p>The clinical record lacked documentation of Resident 25 being informed in writing that she was getting a new roommate.</p> <p>During an interview on 8/23/24 at 10:00 a.m., the Social Services Director indicated if a resident got a new roommate they were to be informed and it should be documented in the clinical record.</p> <p>During an interview on 8/23/24 at 1:00 p.m., the Director of Nursing (DON) indicated if a resident was notified of a change or new roommate it should be documented in the clinical record.</p> <p>On 8/27/24 at 11:30 a.m., the DON indicated they did not notify the residents in writing when they were getting a new roommate.</p> <p>On 8/26/24 at 2:17 p.m., the DON provided a policy titled, Resident Discharge and Transfer Policy, dated 11/24/14 and indicated it was the current policy being used by the facility. A review of the policy indicated [NAME] and Associates, Inc., has implemented the Resident discharge and Transfer policy in the interest of complying with all applicable laws, regulations and statutes surrounding the discharge or transfer of residents within the facility.</p> <p>3.1-3(v)(2)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>35099</p> <p>Based on record review and interview, the facility failed to ensure a resident was referred to the State-designated authority contractor for a Level II Screening (PASARR) for a new mental illness diagnosis evaluation for 1 of 1 residents reviewed. (Resident 53)</p> <p>Findings include:</p> <p>On 8/23/24 at 11:00 a.m., Resident 53's clinical record was reviewed. The diagnosis included, but was not limited to, bipolar disorder. On 12/9/21 Resident 53 received a new diagnosis of bipolar disorder. Resident 53 was not referred for a new Level II screening.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 4/3/24, indicated Resident 53 was cognitively intact.</p> <p>During an interview on 8/23/24 at 11:42 a.m., Social Service Director 3 indicated a PASARR Level II should have been done for Resident 53.</p> <p>On 8/23/24 at 1:21 p.m., the Director of Nursing Services (DON) indicated the facility followed the Indiana Guidelines for PASARR Level II assessments, which indicated a Level II PASARR evaluation is performed to identify the specialized needs of individuals with mental illness and intellectual disability/developmental disability.</p> <p>3.1-16(d)(1)(A)</p> <p>3.1-16(d)(1)(B)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>36746</p> <p>Based on observation, record review, and interview, the facility failed to provide ADL's (Activities of Daily Living) for a dependent resident for 1 of 2 residents reviewed. A resident with facial hair was not assisted with shaving. (Resident 62)</p> <p>Findings include:</p> <p>During an observation on 8/22/24 at 9:14 a.m., Resident 62 was observed in bed with multiple one half inch gray hairs protruding from her chin.</p> <p>During an observation on 8/26/24 at 10:22 a.m., Resident 62 was observed in bed with multiple one half inch gray hairs protruding from her chin.</p> <p>During an observation on 8/27/24 at 9:00 a.m., Resident 62 was observed with multiple one half inch gray hairs protruding from her chin. During an interview at that time, Resident 62 indicated the staff had not offered to assist with the removal of the facial hair. She indicated she was not aware the hair was so long on her chin.</p> <p>During an interview on 8/27/24 at 9:05 a.m., the Director of Nursing indicated the facial hair for residents should have been removed during the residents shower days.</p> <p>On 8/27/24 at 9:34 a.m., Resident 62's clinical record was reviewed. The diagnosis included, but was not limited to, weakness.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident 62 was cognitively intact and she required partial to moderate assist for shaving.</p> <p>A Care Plan, dated 7/29/24, indicated Resident 62 was unable to independently perform late loss ADLs related to weakness, and required assistance with hygiene. The interventions included, but were not limited to, assist Resident 62 with hygiene.</p> <p>A CNA Shower Review Sheet, dated 8/1/24, indicated resident 62 received a shower.</p> <p>A CNA Shower Review Sheet, dated 8/5/24, indicated resident 62 received a shower.</p> <p>A CNA Shower Review Sheet, dated 8/8/24, indicated resident 62 received a shower.</p> <p>A CNA Shower Review Sheet, dated 8/12/24, indicated resident 62 received a shower.</p> <p>A CNA Shower Review Sheet, dated 8/15/24, indicated resident 62 received a shower.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 10:41 a.m., the Director of Nursing provided a policy titled Activities of Daily Living (ADL), Supporting, dated 3/2018, and indicated it was the current policy being used by the facility. A review of the policy, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>3.1-38(a)(3)(D)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38466</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident diagnosed with edema and congestive heart failure received services and treatments for 1 of 1 resident reviewed for lower extremity edema. The facility failed to ensure daily weights, monitoring for side effects of edema, and that daily compression stockings were in place. (Resident 39)</p> <p>Findings include:</p> <p>During an observation on 8/20/24 at 12:15 p.m., Resident 39 was in her room sitting in her wheelchair eating lunch. Resident 39's uncovered left lower leg and foot were observed to be swollen. During an interview at that time, Resident 39 indicated the prescribed water pill (diuretic) did not work as well as it used to work which caused the lower leg and foot to swell. The resident indicated she did not wear compression stockings.</p> <p>During an observation on 8/21/24 at 8:30 a.m., Resident 39 was in her room sitting in her wheelchair eating breakfast. Resident 39's uncovered left lower leg and foot were observed to be swollen.</p> <p>During an observation on 8/23/24 at 11:39 a.m., Resident 39 was in her room resting in bed and her uncovered left lower leg and foot were observed to be swollen.</p> <p>During an observation on 8/26/24 at 8:25 a.m., Resident 39 was in her room sitting in her wheelchair eating breakfast. Resident 39's uncovered left lower leg and foot were observed to be swollen.</p> <p>During an observation on 8/26/24 at 2:29 p.m., Resident 39 was in her room resting in bed and her uncovered left lower leg and foot were observed to be swollen.</p> <p>During an observation on 8/27/24 at 9:10 a.m., Resident 39 was observed sitting in her wheelchair in her room. Resident 39 was observed wearing black zippered compression stockings on both lower legs. The compression stockings covered her toes to the just below the knees. During an interview at that time, Resident 39 indicated this was the first time since her admission into the facility that she had worn compression stockings. The black compression stockings were her own personal stockings. Staff had asked her several times to put on compression stockings; however, she declined as she didn't like them. The resident's weights were not taken on a consistent basis.</p> <p>Resident 39's clinical record was reviewed on 8/23/24 at 2:52 p.m. The diagnoses included, but were not limited to, edema, HTN (hypertension), COPD (chronic obstructive pulmonary disease), and CHF (congestive heart failure).</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/19/24, indicated Resident 39 was cognitively intact.</p> <p>Resident 39's care plan included, but were not limited to,</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 39 had the potential for fluid volume excess/exacerbation related to CHF, initiated on 1/2/24. Resident was identified as non-compliant with daily weights on 8/23/24. The interventions included, but were not limited to, staff were to assess the resident and report weight gain and worsening edema to the physician.</p> <p>CNA assignment sheet indicated Resident 39 was to have daily weights taken, revised on 6/26/24.</p> <p>Resident to wear compression stockings daily, initiated on 3/18/24. The care plan identified Resident 39 as being non-compliant at times with wearing the compression stockings, on 8/26/24.</p> <p>1. Physician orders included, but were not limited to, obtain and record daily weights upon rising before breakfast. Notify MD [Medical Doctor] if weight gain is 2 lbs [pounds] daily or 5 lbs [pounds] in a week. Daily at 7:00 a.m. Start date was 1/2/24 and was discontinued on 8/21/24.</p> <p>On 8/26/24 at 11:50 a.m., the Director of Nursing provided a copy of Resident 39's Medication Administration Record / Treatment Administration Record (MAR/TAR) documents from January 2024 through August 2024. A review of the MAR/TAR documents indicated the following dates lacked staff initials to validate a daily weight had been recorded in the clinical record as indicated by physician orders:</p> <ul style="list-style-type: none"> - 3 of 29 opportunities during February - 9 of 31 opportunities during March - 13 of 30 opportunities during April - 6 of 31 opportunities during May - 5 of 30 opportunities during June - 10 of 31 opportunities during July - 6 of 21 opportunities during August <p>2. Physician orders included, but were not limited to, monitor for increased edema, shortness of breath and lung sounds. Notify MD [Medical Doctor] if condition declines. Document resident status every shift. Start date was 1/2/24 with no identified end date noted.</p> <p>The MAR/TAR documents indicated the following dates lacked staff initials that validated Resident 39's edema was monitored and recorded in the clinical record for each shift as indicated by physician orders:</p> <p>7/17/24 - evening shift</p> <p>7/18/24 - night shift</p> <p>7/19/24 - day shift</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Physician orders included, but were not limited to, compression stockings daily, once a day upon rising at 7:00 a.m . start date was 3/18/24 with no identified end date noted.</p> <p>The MAR/TAR documents indicated no compression stockings were applied to Resident 39's lower extremity on 7/19/24 as indicated by the physician orders.</p> <p>The clinical record lacked documentation that Resident 39's edema was monitored as prescribed by the physician as indicated by:</p> <ul style="list-style-type: none"> - daily weights were not taken and recorded - daily monitoring for increased edema were not completed and recorded - compression stockings were not applied daily and recorded accordingly <p>During an interview on 8/23/24 at 3:45 p.m., the Director of Nursing indicated that Resident 39's original physician order was for daily weights. The resident refused daily weights at times and so the order was changed to weekly weights on 8/21/24. The staff initials on the MAR/TAR indicated the weights were obtained or if the resident refused to be weighed. The MAR/TAR also indicated that the monitoring of the resident's edema was performed as well as applying the compression stockings. If no initials were listed on a specific date on the MAR/TAR, then that action had not completed.</p> <p>During an interview on 8/26/24 at 8:30 a.m., Unit Manager 4 indicated Resident 39's physician ordered compression stockings to be worn daily. Resident 39 tended to refuse to wear the stockings.</p> <p>During an interview on 8/26/24 at 3:17 p.m., the Director of Nursing indicated Resident 39 frequently refused to wear the compression stockings. The Director of Nursing indicated staff were to apply the compression stockings prior to Resident 39 getting out of bed and to remove them in the evening when the resident retired for the night. The Director of Nursing was unsure why the MAR/TAR indicated Resident 39 was wearing the compression stockings when she was observed to not have them on her person.</p> <p>On 8/26/24 at 1:30 p.m., the Director of Nursing provided a copy of the Administering Medications policy, dated 12/2012, and indicated it was the current policy in use by the facility. A review of the policy indicated, medications must be administered in accordance with the orders, including any required time frame . During an interview at that time, the Director of Nursing indicated this policy included residents treatments and services to promote the well-being of the resident.</p> <p>3.1-37(a)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45292</p> <p>Based on interview and record review, the facility failed to follow the current vaccine administration guidelines for the pneumococcal vaccine for 1 of 8 residents reviewed for vaccination records. The CDC (Centers for Disease Control and Prevention) recommended pneumococcal vaccine series was not given for one resident. (Resident 27)</p> <p>Finding includes:</p> <p>On 8/20/24 at 11:50 a.m., Resident 27's clinical record was reviewed and indicated the following:</p> <ul style="list-style-type: none"> - Resident 27's immunization records indicated Resident 27 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 11/20/20, at an outside care setting prior to admission, but lacked documentation of any pneumococcal conjugate (PCV 13, 15, or 20) vaccines. - Resident 27's diagnoses included, but were not limited to, peripheral vascular disease (a chronic disorder that causes blood vessels outside of the heart to narrow, block, or spasm, reducing blood flow to organs like the brain and legs), and chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly). - Resident 27 was of age [AGE] years of age or older. <p>On 8/22/24 at 9:30 a.m., the DON (Director of Nursing) provided the informed consent form indicating Resident 27 had elected to receive the recommended pneumococcal vaccinations.</p> <p>During an interview on 8/23/24 at 11:55 a.m., the DON indicated that Resident 27 should have received both types of pneumococcal vaccination.</p> <p>On 8/20/24, the DON provided a policy, dated for 11/8/16, and titled, Clinical - Pneumonia Vaccination Policy, and indicated it was the policy currently in use. The policy indicated that both the pneumococcal conjugate vaccine and pneumococcal polysaccharide vaccine should be administered routinely in a series to all adults age [AGE] years and older as well as for adults with certain chronic conditions including chronic cardiac and kidney diseases.</p> <p>On 8/23/24 at 10:00 a.m., a review of the CDC guidelines at the following website regarding pneumococcal vaccine timing for adults (cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html#note-pneumo), dated with an addendum update 6/27/24, indicated that chronic cardiovascular diseases and chronic kidney conditions were medical conditions are recommended for adults 19 through [AGE] years of age in addition to being recommended for adults [AGE] years of age and older.</p> <p>3.1-13(a)</p>		