

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  05/12/2026
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure follow-up for physician orders and instructions for care were obtained for a new positioning device (splint) following an off-site medical appointment for 1 of 1 resident reviewed for splints. (Resident 98) Findings includes: On 5/6/26 at 1:20 p.m., Resident 98 was observed sitting in a rocking chair in the activity room. Resident 98 was observed wearing a black positioning device (splint) on her left wrist. During an interview at that time, Resident 98 indicated she had worn the splint for a month or so. On 5/6/26 at 1:02 p.m., Resident 98's clinical record was reviewed. The diagnosis included, but was not limited to, a fractured carpal bone (small bone located in the left wrist). The fracture occurred on 2/20/26 as a result of a fall. The admission MDS (Minimum Data Set) assessment, dated 2/19/26, indicated Resident 98 was severely cognitively impaired. A progress note, dated 2/20/26 at 6:01 p.m., indicated Resident 98 had sustained a fall while in the nursing facility and as a result fractured her left wrist. Resident 98 had been transferred to the hospital emergency room for evaluation and treatment. A progress note, dated 3/30/26 at 10:54 a.m., indicated Resident 98 was accompanied by an unidentified Certified Nurse Aide (CNA) for a follow-up medical appointment with the orthopedic physician related to the fractured wrist. Resident returned to the facility with removal of cast. left forearm. resident has on a black splint with tie string. Resident is to wear splint at all times except for bathing. no paperwork received at this time and the CNA reported that the doctor office will call facility with the follow-up. Resident 98's clinical record lacked an updated physician order and associated instructions regarding the use and care of the splint, documentation related to the facility staff having contacted the physician for an updated physician order and associated instructions, and a revised care plan related to the new splint device. During an interview on 5/11/26 at 9:45 a.m., Unit Manager 3 indicated Resident 98's care plan had not been revised to include the new splint device until 5/8/26. During an interview on 5/11/26 at 11:18 a.m., the Director of Nursing (DON) indicated Resident 98's care plan should have been updated in March when she began wearing the splint. During an interview, on 5/11/26 at 1:30 p.m., the DON indicated the clinical record lacked a physician's order that indicated Resident 98 no longer required a cast and was to utilize a splint for the resident's left wrist. The clinical record also lacked the physician's instructions regarding the use and care of the splint. The nursing staff should have followed up with the physician. During an interview on 5/12/26 at 9:00 a.m., Unit Manager 3 indicated on 2/20/26 Resident 98 fell and sustained a fractured wrist. She wore a cast until 3/30/26 at which time the physician removed the cast and then applied a black splint. The physician's office neglected to provide to the facility, a new order for the splint and the associated instructions for the splint. The facility staff should have contacted the physician to obtain current medical information related to the resident's updated health status. During an interview on 5/12/26 at 11:15 a.m., the DON indicated the facility lacked a policy for obtaining updated physician orders, progress notes, and specific instructions for the facility. On 5/11/26 at 1:00 p.m., the DON provided a copy of the Care Plan, Comprehensive Person-Centered policy, dated December 2016, and indicated it was the current policy in use by the facility. A review of the document indicated, .Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(1)</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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