PRINTED: 01/11/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/29/2023	
	PROVIDER OR SUPPLIEI	ALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX	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
TAG K 0000	REGULATORY OF	CLSC IDENTIFYING INFORMATION		IAG	DE TELEVET,		DATE
Bldg. 01	Code Recertification conducted on 10/30 by the Indiana Dep accordance with 42 Survey Date: 12/29 Facility Number: 12/29 Facility Number: 100 At this PSR survey and Living Communicompliance with Reference with Referen	2000220 155327 267650 , University Heights Health mity was found in substantial equirements for Participation in 1, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), and 410 IAC 16.2. surveyed using Chapter 19,	K 0	000	January 9, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compli Event ID: R1C321 Dear Mrs. Buroker: Please find enclosed the Pla Correction for the Life Safety Recertification survey condu on 01/02/2024. This letter is inform you that the plan of correction attached is to sen University Heights Health & Community credible allegatic compliance. We allege substantial compliance on Ja 9, 2024. If you have any further ques please do not hesitate to cor me at 317-885-7050 Sincerely, Benjy Grzych, HFA Administrator	ance in of / Code icted icted ve as Living on of anuary	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

 Benjy Grzych
 HFA
 01/10/2024

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155327		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/29/2023				
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage providing facility storage services. Quality Review completed on 01/04/24				University Heights Health and Living			
					Submission of this plan of correction in no way constitute an admission by University Heights Health and Living or it management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nu care or other services provided this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	s e rvey rsing d in		
K 0930 SS=A Bldg. 01	Gas Equipment - I The storage and unreservoir contained comply with section (NFPA 99). 11.7 (NFPA 99)	Liguid Oxygen Equipment Liquid Oxygen Equipment use of liquid oxygen in base rs and portable containers ons 11.7.2 through 11.7.4 on and interview, the facility	II A	220	I. The competitive actions to be		01/00/2024	
	Daseu on observatio	on and interview, the facility	K 09	930	I. The corrective actions to b	е	01/09/2024	

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Event ID:

VVWT22 Facility ID: 000220

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155327		î ´	JILDING	onstruction 01	(X3) DATE S COMPL 12/29/	ETED	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY			•	1380 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	from the use of liqua patient bed location 99, Health Care Face	f 124 resident sleeping rooms id oxygen containers stored in on or patient care room. NFPA cilities Code, 2012 Edition, s the maximum total quantity of			accomplished for those residents found to have been affected by the deficient practice.	1	
	liquid oxygen perm patient bed location 120 L (31.6 gallons location or patient of separated from the barriers and horizon minimum fire resist accordance with the Section 7.2.4.3.10 r in horizontal exits s automatic-closing. affect two residents	itted in storage and in use in a for patient care room shall be a provided that the patient bed care room, or both, are remainder of the facility by fire atal assemblies having a cance rating of 1 hour in adopted building code. LSC requires all fire door assemblies hall be self-closing or This deficient practice could, staff and visitors.			The community failed to ensure that liquid oxygen equipment, was not in use, was being stored in resident room 200 and 407. Administrator has in-serviced clinical, therapy, housekeeping maintenance staff to ensure the all liquid oxygen equipment is returned to the certified oxyger room when not in use. See attached in-service documentation that was conducted between 1/5- 1/8. II. The facility will identify	that red The the g, nat	
	and the Maintenance 10:48 a.m. on 12/29 container was store 200 and in resident the two resident sle separated from the barriers and horizon minimum fire resist corridor door to each automatic closing a minimum 45-minut affixed to the door, of the observations, facility was awaitin whether or not the obe removed from the agreed a liquid oxygeach of the two residents.	ons with the Administrator the Director at 10:40 a.m. and at 20/23, one liquid oxygen d in resident sleeping Room sleeping Room 407. Each of the ping rooms was not remainder of the facility by fire that assemblies having a than ance rating of 1 hour. The the room was not self-closing or and was not equipped with a the fire resistance rating label Based on interview at the time the Administrator stated the the guidance from IDOH on the property of the ping rooms but the resident sleeping rooms but the gen container was stored in dent sleeping rooms with the the ded with a minimum fire			other residents that may potentially be affected by the deficient practice. Staff, residents, and visitors in 200 and 400 halls have the potential to be affected by the alleged deficient practice. III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur. A new TELS task is in place for every week to inspect residen rooms to ensure there is no licoxygen equipment not in use.	the ic	

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Event ID:

VVWT22 Facility ID: 000220

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155327	B. WING		12/29/2023	
	PROVIDER OR SUPPLIER	L ALTH AND LIVING COMMUNITY	1380 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S JAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
IAG	resistance rating of These findings were Administrator and t during the exit conf	1 hour. e reviewed with the he Maintenance Director erence. s cited on 10/31/23. The facility a systemic plan of correction		(See attached TELS task labe "University Height Oxygen Equipment Room Inspection). IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities at Clinical team will audit skilled resident rooms during their site visits and annual CQR to ensuthat all no used equipment is rebeing stored in them.	nd e ure	
K 9999						
Bldg. 01			K 9999	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.	1	
				The community failed to ensur that liquid oxygen equipment, was not in use, was being stor in resident room 200 and 407. Administrator has in-serviced to clinical, therapy, housekeeping maintenance staff to ensure the all liquid oxygen equipment is returned to the certified oxygen room when not in use. See attached in-service documentation that was	that red The the g, aat	

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Event ID: VVWT22 Facility ID: 000220

conducted between 1/5- 1/8.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155327		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLETI B. WING 12/29/20			ETED	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY				1380 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	II. The facility will identify other residents that may potentially be affected by the deficient practice. Staff, residents, and visitors in 200 and 400 halls have the potential to be affected by the alleged deficient practice. III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur. A new TELS task is in place for every week to inspect resident rooms to ensure there is no licoxygen equipment not in use. (See attached TELS task labe "University Height Oxygen Equipment Room Inspection). IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities at Clinical team will audit skilled resident rooms during their sit visits and annual CQR to ensuthat all no used equipment is reliefly stored in them.	the ic r t quid led	DATE

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Event ID:

VVWT22 Facility ID: 000220

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED	
155327		155327	B. WING			12/29/2023	
		<u> </u>		CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD		
					COUNTY LINE RD S		
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY			INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0000							
Bldg. 02							
		sit (PSR) to the Life Safety	K 0	000	January 9, 2024		
	Code Recertification	n and State Licensure Survey					
		/23 & 10/31/23 was conducted					
	by the Indiana Depa				Brenda Buroker, Director		
	accordance with 42	CFR 483.90(a).			Long-Term Care Division		
					Indiana State Department of		
	Survey Date: 12/29	0/23			Health		
					2 North Meridian Street		
	Facility Number: 0				Indianapolis, IN 46204		
	Provider Number: 155327						
	AIM Number: 1002	267650			Re: Allegation of Compliar	nce	
	At this PSR survey.	University Heights Health			Event ID: R1C321		
	-	nity was found in substantial			2401113.1410021		
	_	equirements for Participation in			Dear Mrs. Buroker:		
	_	, 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the			Please find enclosed the Plan	of	
	-	etion Association (NFPA) 101,			Correction for the Life Safety		
		SC), and 410 IAC 16.2.			Recertification survey conduct		
	Building 0202 was	surveyed using Chapter 19,			on 01/02/2024. This letter is t		
	Existing Health Car	re Occupancies.			inform you that the plan of		
	_				correction attached is to serve	as	
	This one story facili	ity was surveyed as two			University Heights Health & Li	ving	
	separate buildings d	lue to the construction types			Community credible allegation	-	
	of two sections of th	ne building. Building 0202 was			compliance. We allege		
	constructed in 2012	and was determined to be of			substantial compliance on Jar	nuary	
	Type V (111) const	ruction and fully sprinklered.			9, 2024.	-	
	The facility has a fir	re alarm system with smoke					
	detection in the corr	ridors and in all areas open to			If you have any further question	ons,	
	the corridor. The fa	ncility has battery operated			please do not hesitate to conta	act	
	smoke detectors in	all resident sleeping rooms in			me at 317-885-7050		
		00, 500, 600, 700 and 800 Hall.					
		oke detectors hard wired to the			Sincerely,		
		all resident sleeping rooms in					
		acility has a capacity of 176 and					
	had a census of 136	at the time of this visit.			Benjy Grzych, HFA		
					Administrator	ļ	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	02	COMPL	ETED	
		155327	B. WI	NG		12/29/	/2023
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY			1380 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S APOLIS, IN 46227			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	access were sprinkle facility services wer	residents have customary ered. All areas providing e sprinklered except for one viding facility storage			University Heights Health and Living		
					Submission of this plan of correction in no way constitute an admission by University Heights Health and Living or it management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare or other services provide this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	ts e urvey ursing d in	

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