

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155327	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/27/2015
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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
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/27/15</p> <p>Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650</p> <p>At this Life Safety Code survey, University Heights Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Building 0102 was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0102 constructed prior to 2003 was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm</p>	K 0000	<p>Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. University Heights Health and Living Community respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Survey Re-visit on or after 08.14.15.</p>	

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

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.

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K 0018 SS=E Bldg. 01	<p>system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms in the 100, 200, 300, 400, 500, 600, 700 and 800 Hall. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms in the 900 Hall. The facility has a capacity of 176 and had a census of 157 at the time of this visit.</p> <p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>			

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	<p>Based on observation and interview, the facility failed to ensure 1 of over 75 corridor 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 20 residents, staff and visitors in the vicinity of the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 07/27/15, the Dietary Employee entrance from the Main Dining Room failed to latch into the door frame because the latching mechanism did not protrude into the latching plate on the door frame. The Main Dining Room is open to the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>	K 0018	<p>CorrectiveAction: It is the practice of this community to ensure there is no impediment to the closing of the doors. The strike plate on the identified door was replaced with an extended strike plate on 07.28.15. How others are identified: An inspection of all doors was completed to ensure proper latching. Systemic Change: The Maintenance Director/designee will complete monthly inspections of all doors to ensure proper latching. Doors requiring repair will be repaired immediately. The Executive Director will be made aware of identified concerns and assist with compliance. Monitoring: The CQR Environmental audit tool (attachment #1)will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by MDS Coordinator and/or designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee.</p>	08/14/2015			

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K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 in 9 of 3 egress paths. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 07/27/15, the egress path for the service</p>	K 0038	<p>Corrective Action: It is the practice of this community to ensure there are not more than one delayed egress lock devices in any egress path. The identified device was replaced with a release button on 08.03.15. How others are identified: An inspection of all exit doors was completed on 07.28.15 to ensure there was not more than one delayed egress lock device in any egress path. Systemic Change: The Maintenance Director/designee will complete monthly inspections of all egress paths and to ensure there are not more than one delayed egress lock devices present. Lock devices requiring repair/replacement will be repaired/replaced immediately. The Executive Director will be made aware of identified concerns and assist with compliance. Monitoring: The CQR Environmental audit tool (attachment#1) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by MDS Coordinator and/or designee. The tool will be</p>	08/14/2015

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K 0069 SS=D Bldg. 01	<p>corridor was provided with two delayed egress locks. The service corridor is marked as a facility exit with an exit sign. The service corridor exit door near the Main Dining Room and the service corridor door to the outside of the building were each provided with a delayed egress lock. Based on interview at the time of observation, the Maintenance Director acknowledged the egress path for the service corridor which is marked as a facility exit was provided with two delayed egress locks.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection</p>	K 0069	<p>reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee.</p> <p>CorrectiveAction: It is the practice of this community to ensure the kitchen exhaust system is inspected semiannually. The exhaust system is scheduled for inspection again on 08/20/15. How others are identified: There is only one kitchen exhaust system that requires monitoring and semiannual inspection. The Maintenance Director and Executive Director verified the current schedule for the identified exhaust system.</p>	08/14/2015

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	<p>Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Service Report" documentation dated 03/03/15 during record review with the Maintenance Director from 9:00 a.m. to 11:50 a.m. on 07/27/15, documentation of kitchen exhaust system inspection every six months was not available for review. The aforementioned documentation was the only kitchen exhaust system inspection record for the most recent twelve month period. Based on observation with the Maintenance</p>		<p>SystemicChange: The Maintenance Director/designee updated the cleaning schedule for the kitchen exhaust system to ensure the cleaning dates are within the established semiannual standard. Monthly preventative maintenance inspections will be performed by the Maintenance Director/designee. The Executive Director will review preventative maintenance completion to ensure compliance. Monitoring: The CQR Environmental audit tool (attachment#1) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by MDS Coordinator and/or designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee.</p>	

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K 0147 SS=E Bldg. 01	<p>Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 07/27/15, a 360 Services inspection sticker dated 03/03/15 was the only sticker affixed the range hood in the kitchen. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of semiannual kitchen exhaust system inspection every six months was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Activities Office.</p>	K 0147	<p>CorrectiveAction: It is the practice of this community to ensure extension cords, including power strips, are not used as a substitute for fixed wiring. The identified air conditioner unit was removed from service on 07.27.15 How othersare identified: An inspection was completed by the Maintenance Director/designee to ensure extension cords, include power strips, are not being used as a substitute for fixed wiring on 07.30.15. Systemic Change: The</p>	08/14/2015

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K 0000  Bldg. 02	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 07/27/15, an operable window mounted air conditioner was plugged into a power strip in the Activities Office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/27/15</p>			K 0000	<p>Maintenance Director/designee will complete a monthly facility inspection to ensure extension cords, including power strips, are not used as a substitute for fixed wiring. The Maintenance Director will take immediate corrective action when non-compliance is identified. Monitoring: The CQR Environmental audit tool (attachment#1) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months byMDS Coordinator and/or designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an actionplan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee.</p> <p>Submission of this plan of correction does not constitute anadmission by University Heights Health and Living Community or its managementcompany that the allegations contained in the survey report is a true andaccurate portrayal of the</p>		

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	<p>Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650</p> <p>At this Life Safety Code survey, University Heights Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Building 0202 was surveyed using Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202 was constructed in 2012 and was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms in the 100, 200, 300, 400, 500, 600, 700 and 800 Hall. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms in the 900 Hall. The facility has a capacity of 176 and had a census of 157</p>		<p>provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. University Heights Health and Living Community respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Survey Re-visit on or after 08.14.15.</p>	

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	at the time of this visit.  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.				