

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 DATE
K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/12/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/24/15</p> <p>Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890</p> <p>At this PSR survey, University Place Inc. was found not in compliance with Requirements for Participation in 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility located on the first floor on one wing of a two story building was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery powered smoke detectors in all resident</p>	K 0000	<p>University Place ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. This POC should not be construed as an admission of any all alleged deficiency cited. The Provider submits the POC with the intention that it be inadmissible by any third party in any civil or criminal against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the provider determines that the disputed findings, (1)are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS") the State of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 and the federal Rules of Evidence and should be inadmissible in any proceedings on that basis.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 DATE
K 0056 SS=E Bldg. 01	<p>sleeping rooms. The facility has a capacity of 30 and had a census of 19 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the overhang located outside the northeast exit.</p> <p>Quality Review completed 09/29/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on record review and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 3 exits with outside canopies in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999</p>	K 0056	Architects and Corporate officials were notified of the concern and blue prints were being reviewed for the 13 year history of construction All outdoor canopies were inspected for similar concerns Certified Fire Protection Specialist(Brenneco) was notified and a quote will be provided and acted upon as	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/24/2015
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 DATE	
	<p>Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 8 residents on Northeast hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 09/24/15 at 3:01 p.m. with the Administrator, documentation in a letter from the sprinkler vendor indicated there was a sprinkler head installed above the wood ceiling of the Northeast exit overhang inside the attic area. The entrance overhang was constructed of a wood composite material for the ceiling with interior wood construction which connects to the building and extends fifty six inches in width and lacked outside sprinkler protection. Based on interview at the time of observation, the Administrator acknowledged the lack of sprinkler protection outside and under the aforementioned exit overhang and stated it was constructed of wood.</p> <p>This deficiency was cited on --- -08/12/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		necessary to correct identified deficiencies. A letter on Brenneco letterhead validates that action has been taken and will be completed as scheduled.		

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

PRINTED: 10/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155725	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/24/2015
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 DATE	
	3.1-19(b)				