

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
---	---

(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
--------------------	--	---------------	---	----------------------

K010000	<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: 08/01/13</p> <p>Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, University Nursing Center 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors with battery operated smoke detectors in the resident rooms. The</p>	K010000	<p>Dear Ms. Rhoades, Attached is University Nursing Center's Plan of Correction for the recent annual Life Safety Code inspection. Please accept the plan as written. Thank you, Stephanie Allen, HFA Executive Director University Nursing Center</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: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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>facility has a capacity of 75 and had a census of 54 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(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			
K010025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 08/01/13 at 2:02 p.m., there were four unsealed penetrations in the ceiling of the laundry room measuring one and one half inches each where electrical cables were removed to relocate a breaker box. Measurements were provided by the Environmental Supervisor at the time of observation.</p>	K010025	<p>What corrective actions will be accomplished for those residnets found to have been affected by the deficient practice: The four unsealed penetrations in the ceiling of the laundry room were sealed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a whole facility round looking for unsealed penetrations and will reseal any penetrations needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure no unsealed penetrations exist within the facility. Any unsealed penetrations found will be fixed</p>	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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)		immediately. Documentation by the Environmental Services Manager will exist to ensure rounding is occurring per POC. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure no unsealed penetrations exist within the facility with results of the audit reported to CQI monthly. Executive Director or designee will audit Environmental Services round weekly to ensure compliance. If 95% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(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			
K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could 2 of 5 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Environmental Supervisor on 08/01/13 at 12:40 p.m., the smoke barrier wall lacked a set of double doors in the Cottage. Based on an interview with the Environmental Supervisor at the time of observation, the Cottage smoke barrier</p>	K010027	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Smoke barrier wall on the Cottage had a set of double doors installed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. Environmental Services Manager conducted facility wide round to ensure all smoke barrier walls have double doors installed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Environmental Services Manager or designee will conduct a daily round to ensure all smoke barrier walls have double doors installed. Any smoke barrier wall found to not have double doors installed will be fixed immediately. Environmental Services Manager</p>	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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	
	doors were removed for the current remodeling project. The Environmental Supervisor stated the double doors entering the Cottage were "convenience doors" separating the Alzheimer's unit from the remainder of the facility. He further stated the doors at the smoke barrier wall that extends into the attic and ends at the roof deck were removed for the current remodeling project and would be replaced at a later date. 3.1-19(b)		or designee will conduct a daily round to ensure compliance. Results will be placed on attached form. How the corrective actions will be monitored to ensure the deficient practice will not recur: Environmental Service Manager or designee will conduct a daily round for 4 weeks and a weekly round for 6 months to ensure compliance with results to CQI. ED or designee will monitor Environmental Service Manager's compliance with the POC weekly. If a 95% threshold is not acheived with any of the above indicators, an internal POC will be devised to ensure compliance. Date systemic changes will be completed: 8.31.13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(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			
K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 soiled linen rooms in the Cottage and 1 of 1 laundry rooms, both a hazardous area, were provided with self closers and would latch into the frame. This deficient practice could affect 16 residents in the Cottage and staff in the service corridor.</p> <p>Findings include:</p> <p>a. Based on observation with the Environmental Supervisor on 08/01/13 at 12:55 p.m., there was no self closer on the soiled linen room door located in the Cottage shower room or the corridor door to the Cottage shower room. Based on an interview with the Environmental Supervisor at the time of observation, the soiled linen barrels are stored in the soiled linen room in the Cottage shower room</p>	K010029	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: All residents have potential to be affected by the deficient practice. Self closers that latch into corridor doors were provided to the soiled linen rooms on the Cottage and laundry room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. Environmental Services Manager conducted facility wide audit to ensure all corridor doors needing a self closure had a self closure installed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Environmental Services Manager or designee will monitor corridor doors with</p>	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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>until collected by someone from the laundry and taken to the laundry room.</p> <p>b. Based on observation with the Environmental Supervisor on 08/01/13 at 2:08 p.m., the service hall corridor door entering the dryer side of the laundry room did self close, but it failed to latch into the door frame. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>self closures daily to ensure compliance and will place results from audit on attached form. Any corridor doors found to not have self closures will have self closures installed immediately. How the corrective action will be monitored to ensure the deficient practice will not recur: Environmental Service Manager or designee will conduct a daily round for 4 weeks and a weekly round for 6 months to ensure all corridor doors have self closures that latch with results to CQI. Executive Director or designee will audit Environmental Service Manager's compliance with above POC weekly. If a 95% threshold is not met on any of the above indicators, an internal POC will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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	
K010038 SS=E	<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 1 of 7 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect any residents evacuated through the service hall from the main dining room in the event of an emergency. This deficient practice could affect 16 residents in the Cottage.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 08/01/13 at 12:50 p.m., the Cottage exit door at the end of the corridor which was equipped with electromagnetic locks failed to release when the Environmental Supervisor applied force to the door for twenty five seconds. A sign above the door indicated it would release in 15 seconds. Based on an interview with the Environmental Supervisor at the time of observation, the door was supposed to unlock after 15 seconds.</p>	K010038	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The electromagnetic locks on the Cottage door was replaced to ensure door opens within 15 seconds from applying force. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have potential to be affected by the deficient practice. The Environmental Services Manager audited all exit doors at corridors to ensure release of 15 seconds occurred when force was applied. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily audit to ensure all exit corridor doors open within 15 seconds when force is applied. Issues will be documented on the attached form. Any issues found with compliance will be corrected immediately. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily audit for 4</p>	08/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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)		weeks and then a weekly audit for six months to ensure all exit doors open within 15 seconds of applying force with results to CQI. Executive Director or designee will audit Environmental Service's compliance with the above POC weekly. If a 95% threshold is not met on any of the above indicators, an internal POC will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(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			
K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 6 of 6 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with Environmental Supervisor on 08/01/13 during the tour from 12:00 p.m. to 2:08 p.m., the six battery operated emergency lights observed throughout the facility lit up when the test button was pressed. Based on record review at 11:28 p.m., the "Battery Operated Emergency Lights-Test Log for 2012, the last annual test was conducted on March 8, 2012. Based on</p>	K010046	<p>What corrective actions will be accomplished for those resident found to have been affected by the deficient practice: The annual test for the six battery operated lights was completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Environmental Services Manager completed annual test for six battery operated lights. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will complete the required annual battery operated lights test by next required date as indicated in the Environmental Services Manager's manual. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will complete the required annual battery operated lights test by next required date with documentation within the Environmental Services Manager's manual with results to CQI. The Executive Director will</p>	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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	
	an interview with the Environmental Supervisor at the time of record review, he stated an annual test for the six battery operated lights has not occurred since March of 2012. 3.1-19(b)		audit Environmental Services compliance monthly by reviewing the Maintenance manual. If a 95% threshold is not acheived on any of the above indicators, an internal POC will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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	
K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the water heater room was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 08/01/13 at 2:00 p.m., the gauge on the portable fire extinguisher located in the water heater room indicated the extinguisher needed to be recharged. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010064	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The extinguisher in the water heater room was recharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Environmental Services Manager audited all fire extinguishers in house to ensure they were properly charged. Any found to be uncharged were charged to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily audit of extinguishers to ensure all are properly charged with documentation of audit results completed. Any uncharged extinguishers will be recharged immediately to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice does not recur: The Environmental Services Manager or designee will audit extinguishers daily for 4 weeks and then weekly for 6</p>	08/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
---	---

(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
			months to ensure adequate charging levels with results to CQI. The Executive Director or designee will audit the Environmental Services Manager or designee's compliance weekly. If a 95% threshold is not achieved on any of the above indicators, an internal POC will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(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			
K010069 SS=D	<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 and interview, the facility failed to ensure 2 of 2 kitchen exhaust systems were maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on record review with the Environmental Supervisor on 08/01/13 at 11:40 a.m., the 360 Degree Services kitchen hood cleaning report titled "Service Report" dated 11/29/12 stated, "Could not install hinge kit on fan. Need 2 hinge kits for location. Inaccessible area exist: fans and ductwork. Need to remove nails and caulk from around fan base to enable us to install hinge kit." Based on an interview with the Environmental Supervisor at the time of record review, the facility has plans to replace the existing hood systems at some time in the future therefore no corrections</p>	K010069	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: A new hood has been ordered and will be installed in September 2013. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. Upon installation of new hood, recommended cleaning recommendations will be followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will follow up on service reports immediately and will provide a copy of the service reports to the Executive Director to ensure proper follow up is completed. How the corrective action will be monitored to ensure the deficient practice does not recur: The Environmental Services Manager will provide all service reports to the Executive Director or designee within 24 hours of services rendered. The Environmental Services Manager will follow up on the service reports timely with Executive Director supervision with results</p>	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989		
(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	
	have been made at this time. 3.1-19(b)		to CQI. If a 95% threshold is not acheived on all of the above indicators, an internal POC will be devised to ensure compliance. By what date the systemic changes will be completed: 8.31.13		