

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 03/29/2012
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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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K0000	<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: 03/29/12</p> <p>Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, University Heights Health and Living Community Inc. 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 III (200) 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</p>	K0000	<p>This plan of correction is to serve as University Heights and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by University Heights and Living Community or its management company that the allegations contained in the survey report are 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.</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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	<p>smoke detectors in all resident rooms.</p> <p>The facility has a capacity of 184 and had a census of 140 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/04/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure the Main Dining Room was separated from the corridor by smoke resistant partitions capable of resisting the passage of smoke, or met an Exception. LSC 19.3.6.1, Exception # 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is</p>	K0017	<p>K 017 NFPA 101 Life Safety Code Standard I. Main Dining Room – electronically supervised automatic smoke detection system will be installed by 04.20.2012. II. All other open resident occupied spaces throughout the facility will be audited for electronically supervised automatic smoke detection system. Electronically supervised automatic smoke detection systems will be installed in any open space that does not have these devices. III. The Maintenance Director will report results of the audit to the Administrator or designee. Devices will be installed in any open space that does not currently have one. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further</p>	04/28/2012			

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	<p>located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any resident, staff or visitor 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 11:10 a.m. to 3:20 p.m. on 03/29/12, the Main Dining Room is open to the corridor and is not protected by an electrically supervised automatic smoke detection system. The Main Dining Room is open to the corridor because there are no walls or positive latching doors separating the Main Dining Room from the corridor. Exception #1(b) of LSC 19.3.6.1 was not met because the Main Dining Room is not protected by an electrically supervised automatic smoke detection system, or protected throughout by quick response sprinklers. Based on interview at the time of observation, the Maintenance Director acknowledged the Main Dining Room is open to the corridor</p>		<p>intervention and follow up. Monthly audits will be completed until there is 100 % compliance then annually thereafter IV. The Continuously Quality Review Committee will monitor the audits to ensure that any open resident space has appropriate electronically supervised Automatic smoke detection devices. Completion date: April 28, 2012</p>				

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	and is not provided with smoke detectors or quick response sprinklers. 3-1.19(b)			

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K0029 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 1 of 8 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen entry door from the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:20 p.m. on 03/29/12, the kitchen entry door from the Main Dining Room is not equipped with a positive latching device to latch the door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the kitchen entry door from the Main Dining</p>	K0029	<p>K 029 NFPA 101 Life Safety Code Standard I. A positive latch device will be installed on the kitchen entry door from the main dining room on 04.20.2012 II. An audit was completed on all facility doors serving hazardous areas for a positive latching device. Positive latching devices will be installed on any door serving hazardous areas. III. The Maintenance Director or designee will inspect all facility doors serving hazardous areas for a positive latching device. Results of the audit will be forwarded monthly to the Continuous Quality improvement Committee for any needed intervention and follow up. Monthly audits will be completed until there is 100 % compliance then annually thereafter IV. The Continuously Quality Review Committee will monitor the audits to ensure that any door serving a hazardous any has a positive patching device. Completion date: April 28, 2012</p>	04/28/2012

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	<p>Room is not equipped with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 1 of 6 fire drills conducted prior to 9:00 p.m. on the first shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "TELS: Drills" documentation with the Maintenance Director from 9:30 a.m. to 11:10 a.m. on 03/29/12, documentation for the first shift fire drill conducted on 01/18/12 at 11:00 a.m. did not include the transmission of the fire alarm signal. Written documentation of the fire drill stated</p>	K0050	<p>K050 NFPA 101 Life Safety Code standard I. A first shift fire drill will be conducted by 04.20.2012 and included the transmission of the fire alarm signal. II. An audit was completed on all fire drills for last 12 months to ensure that they included the transmission of the fire alarm signal to the fire alarm signal company. III. The Maintenance Director will complete a monthly audit of fire drills to ensure they include the transmission of the fire signal. Results of the audit will be forwarded monthly to the Continuous Quality Improvement Committee for follow up and intervention. Monthly audits will be completed until there is 100 % compliance then annually thereafter IV. The Continuously Quality Review Committee will monitor the audits to ensure that all fire drills include transmission of the signal to fire alarm signal company. Audits will be complete until there is 100 % compliance,</p>	04/28/2012			

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	"NA" in response to "did alarm company receive the signal from the facility's alarm system" and "silent" in response to "Name of the person you spoke with at the Alarm Company". Based on interview at the time of record review, the Maintenance Director acknowledged documentation of the first shift fire drill conducted on 03/29/12 at 11:00 a.m. did not include transmission of the fire alarm signal. 3.1-19(b)		then annually thereafter. Completion date: April 28, 2012	

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 56 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect residents, staff or visitors in the vicinity of resident room 701.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:20 p.m. on 03/29/12, the smoke detector in the corridor next to resident room 701 was located on the ceiling one foot from an air supply diffuser. Based on interview at the time of the observation, the Maintenance Director acknowledged the smoke</p>	K0052	<p>K052 NFPA 101 Life Safety Code</p> <p>I. The smoke detector in the corridor next to resident room 701 will be relocated 3 feet away from the air supply diffuser by 04.20.2012</p> <p>II. The Maintenance Director or designee conducted an audit of all smoke detectors throughout the facility to ensure that none are located in a direct airflow nor closer than 3 feet from an air supply diffuser. Any smoke detector located within three (3) feet from a air supply diffuser will be re-located.</p> <p>III. The Maintenance Director will forward to the Continuous Quality Review Committee the results of the audit of smoke detectors located near air supply diffuser. The Continuous Quality Review Committee will make any needed interventions or follow up.</p> <p>IV. Audits for smoke detectors near air diffusers will be completed until there is 100 % compliance the annually thereafter.</p> <p>Completion date: April 28, 2012</p>	04/28/2012			

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	<p>detector on the ceiling in the corridor next to resident room 701 was located one foot from an air supply diffuser.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure the documentation for the testing of 5 of 56 smoke detectors was complete. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Integrated Electronics "Inspection and Testing Form" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:10 a.m. on 03/29/12, semiannual functional testing of smoke detectors on 08/29/11 and on 02/02/12 indicated 51 smoke detectors in the facility were tested on each date. Integrated Electronics "Smoke Detector Sensitivity Test Report" documentation dated 11/09/10 indicated there are 56 smoke detectors in the facility. Based on interview at the time of observation, the Maintenance Director acknowledged</p>				

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	documentation of annual smoke detector testing for 5 of 56 smoke detectors was not available for review. 3-1.19(b)			

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K0064 SS=E	<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 13 portable fire extinguishers requiring a 12 year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers, Chapter 4-4.3. This deficient practice could affect any resident, staff or visitor near the Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:20 p.m. on 03/29/12, the maintenance tag on the fire extinguisher in the Mechanical Room indicated the last six year test was completed March 2004. Based on interview at the time of observation, the Maintenance Director acknowledged the most recent six year test was completed March 2004.</p> <p>3.1-19(b)</p>	K0064	<p>K 064 NFPA Life Safety Code</p> <p>I. Fire extinguisher in the Mechanical room will be replaced by 04.20.2012.</p> <p>II. The Maintenance Director completed an audit of all facility fire extinguishers checking for the required 12 year hydrostatic test. Any fire extinguisher which failed to be re – tested was pulled and replaced with a fire extinguisher with a current hydrostatic test.</p> <p>III. The Maintenance Director will forward the audit of the facility fire extinguishers checking for the required 12 year hydrostatic test to the Continuous Quality Review Committee. The Continuous Quality Review Committee will make any needed interventions or follow up.</p> <p>IV. Audits for the facility fire extinguishers checking for the required 12 hydrostatic test will be completed monthly until there is 100 % compliance, then quarterly thereafter. Results of the audits will be forwarded to the Continuous Quality Review Committee for any needed intervention or follow up.</p> <p>Completion date: April 28, 2012</p>	04/28/2012			