

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 06/12/2014
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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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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: 06/12/14</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 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</p>	K010000	<p>This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance. 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 are 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>Type III (200) construction and fully sprinklered except for 1 of 1 concealed spaces in the kitchen. 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 158 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 except for 1 of 1 concealed spaces in the kitchen and one detached garage providing facility storage services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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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>1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual</p>	K010038	<p>1. Corrective Action Necessary signage stating door could be opened by pushing on the door release device for 15 seconds was applied to the service door by the Main Dining Room and the 500 Hall exit door by the Main Dining Room on 06.13.14</p> <p>2. Other residents potential for impact All 9 facility exit doors are equipped with delayed egress were inspected by Maintenance Director for necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3. What measures Maintenance Director will complete an audit of the 9 facility exit doors which are equipped with delayed egress to ensure they have signage stating the door could be opened by pushing for 15 seconds on the door release device.</p> <p>4. Monitored- Quality assurance Maintenance Director will submit exit door audits monthly to the Continuously Quality Assurance Committee the results of findings. Audit results will be presented monthly until 100% compliance is recorded for 2 consecutive</p>	07/01/2014			

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	<p>means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 30 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 1:00 p.m. to 4:40 p.m. on 06/12/14, the service corridor exit by the Main Dining Room and the 500 Hall exit by the Main Dining Room were each marked as a facility exit and each exit door is equipped with a delayed egress lock but is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. Each exit door released within 15 seconds when the door was pushed with the application of force two separate times. Based on interview at the time of observation, the Maintenance</p>		<p>months then quarterly thereafter. Administrator will monitor for compliance.</p> <p>5.Compliance date July 1, 2014</p>	

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	<p>Director stated the aforementioned exit doors are each a facility exit, are each equipped with a delayed egress lock and acknowledged the two exits are not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Dining Room.</p> <p>Findings include:</p>			

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K010056 SS=E	<p>Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 06/12/14, the service corridor exit by the Main Dining Room and the 500 Hall exit by the Main Dining Room were each marked as a facility exit, each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated facility residents who have a clinical diagnosis to be in a secure building reside in the 300 Hall and acknowledged the four digit code was not posted at the aforementioned facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</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</p>			

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	<p>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 observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 concealed spaces in the kitchen. Exception number 1 in NFPA 13, 1999 Edition, Section 5-1.1 states for locations permitting omission of sprinklers, see 5-13.1 for concealed spaces. Section 5.13.1.1 states all concealed spaces enclosed wholly or partly by exposed combustible construction shall meet an exception or be protected by sprinklers. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the adjoining Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 06/12/14, the walk in freezer and cooler in the kitchen are located next to one another and a fifteen foot long by ten feet</p>	K010056	<p>1. Corrective Action Sprinkler coverage for the concealed spaces above the walk-in refrigerator / freezer and the closet in the 900 Hall therapy gym will be installed by July 3, 2014</p> <p>2. Other residents potential for impact – An audit was conducted by the Maintenance Director to identify any other concealed areas and identify any areas with sprinkler. If any are found then those areas will have a sprinkler installed.</p> <p>3. What measures – The Maintenance Director will complete a monthly audit of the facility to determine if all concealed spaces have sprinkler system.</p> <p>4. Monitored-Quality assurance – The Maintenance Director will report findings of the audit of concealed spaces to the Continuous Quality Improvement Committee. The Continuous Quality Improvement Committee will review the result of the</p>	07/03/2014			

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K010147 SS=D	<p>deep by two feet high concealed space above the freezer and cooler was not sprinklered. The ceiling and three walls of the concealed space consisted of drywall but the wall of the concealed space above the entrance to the freezer and cooler consisted of wood studs and a wood wall which had vinyl covering the wood wall on the kitchen side of the concealed space. An access door for the concealed space above the freezer and cooler entrance doors allowed for the observation of the fifteen foot long by two foot high wood construction of the wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned concealed space in the kitchen was of combustible construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in</p>		<p>audit. Sprinkler Heads will be installed on any other concealed spaces which are not sprinkled. Administrator will monitor for compliance. Compliance date July 3, 2014</p>	

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	<p>accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 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 5 residents, staff and visitors in the Employee Lounge.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 06/12/14, a refrigerator was plugged into a power strip and a microwave oven was plugged into a second power strip in the Employee Lounge. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were being used as a substitute for fixed wiring in the Employee Lounge.</p> <p>3.1-19(b)</p>	K010147	<p>1. Corrective Action power strips used for refrigerator and microwave were removed immediately. Refrigerator and microwave were plugged into a fixed wire receptacle.</p> <p>2. Other residents potential for impact –an audit was conducted of the rest of the facility for power strips which were in use as a substitute for fixed wiring. Any were removed and item plugged into a fixed wiring receptacle.</p> <p>3. What measures - The Maintenance Director or designee will conduct a facility audit weekly for 2 months for electrical devices plugged into power strips. Once there is 100 % compliance for 2 consecutive weeks, audits will be conducted monthly thereafter. Results of the audits will be submitted for Continuous Quality Improvement committee for intervention and follow up.</p> <p>4. Monitored- Quality assurance The Maintenance Director will submit the results of the audits for the power strips to the Continuous Quality Improvement Committee for intervention and follow up. Administrator will monitor for compliance.</p> <p>Compliance date: July 1, 2014</p>	07/01/2014			

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K020000	<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: 06/12/14</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 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 constructed in</p>	K020000	<p>This plan of correction is to serve as University HeightsHealth and Living Community's credible allegation of compliance. Submission of this plan of correction does notconstitute an admission by University Heights Health and Living Community orits management company that the allegations contained in the survey report area true and accurate portrayal of the provision of nursing care and otherservices in this facility. Nor does thissubmission constitute an agreement or admission of the survey allegations.</p>		

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K020027 SS=E	<p>2012 was determined to be of Type V (111) construction and fully sprinklered except for the Therapy Room closet. 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 158 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered except for the Therapy Room closet. All areas providing facility services were sprinklered except for one detached garage providing facility storage services.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at			

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	<p>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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect twenty residents, staff and visitors in the 900 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 06/12/14, the set of smoke barrier doors in the corridor by Speech Therapy swing in the opposite direction and are not equipped with an astragal, rabbet or bevel at the meeting edge. In addition, a one half inch gap was noted between the set of smoke barrier doors when the door set was fully closed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned smoke barrier door set each swing in the opposite direction and</p>	K020027	<p>1. Corrective Action Surface mounted Astragal was mounted on smoke barrier doors next to the Speech therapy room on 900 Hall on June 25, 2014.</p> <p>2. Other residents potential for impact An audit was completed on 900 Hall and determined there were two other smoke barrier doors that were similarly affected. Surface mounted Astragals were mounted on the two other smoke barrier doors on 900 Hall on June 25, 2014.</p> <p>3. What measures Maintenance Director will conduct an audit of the rest of the community to see if any other smoke barrier doors have a ½ inch gap and thus meet criteria for surface mounted astragal and installed if needed. Maintenance Director will submit audits to Continuous Quality Improvement Committee for further evaluation, intervention and followup.</p> <p>4. Monitored-Quality assurance Maintenance Director will submit audits to Continuous Quality Improvement Committee</p>	07/01/2014

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K020056 SS=E	<p>are not equipped with an astragal, rabbet or bevel.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to ensure a sprinkler was installed in 1 of 1 Therapy Room closets to provide coverage for all portions of the building. This deficient practice could affect 10 residents, staff and visitors in the Therapy Room.</p> <p>Findings include:</p>	K020056	<p>forfurther evaluation, intervention and follow up. Administrator will monitor forcompliance.</p> <p>5.Compliancedate July 1, 2014</p> <p>1.CorrectiveAction Sprinkler coverage for the concealed spaces above the walk-inrefrigerator / freezer and the closet in the 900 Hall therapy gym will beinstalled by July 3, 2014</p> <p>2.Otherresidents potential for impact – An audit was conducted by the MaintenanceDirector to identify any other concealed areas and identify any areas</p>	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2014	
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			
(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>Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 06/12/14, the closet in the Therapy Room by the restroom was not sprinklered. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned closet was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p>				<p>withsprinkler. If any are found then those areas will have a sprinkler installed.</p> <p>3.What measures – The Maintenance Director will complete a monthly audit of the facility to determine if allconcealed spaces have sprinkler system.</p> <p>4.Monitored-Quality assurance – The Maintenance Director will report findings of theaudit of concealed spaces to the Continuous Quality Improvement Committee. TheContinuous Quality Improvement Committee will review the result of the audit.Sprinkler Heads will be installed on any other concealed spaces which are notsprinkled. Administrator will monitor for compliance.</p> <p>Compliance dateJuly 3, 2014</p>		