

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  09/09/2016
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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
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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: 09/09/16</p> <p>Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890</p> <p>At this Life Safety Code 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 sleeping rooms. The facility has a</p>	K 0000	<p><b>This Plan of Correction is prepared and executed because it is required by provisions of the State and Federal Law, and not because University Place, Inc. agrees with the allegations contained therein. University Place maintains that each deficiency does not jeopardize the health and safety of its residents, nor is it of such character as to limit our capability to provide adequate care. University Place, Inc. respectfully requests that paper compliance be considered for this Plan of Correction.</b></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 0029 SS=E Bldg. 01	<p>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 on 09/12/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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 1 corridor doors to the linen room on the North hall, a hazardous area, was provided with self-closing device causing the doors to automatically close and latch into the door frame. This deficient practice could affect all 14 residents in the North hall.</p> <p>Findings include:</p>	K 0029	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The latch will be and was repaired the evening of September 9, 2016 by Plant Director Paul Dotas.</p>	09/16/2016

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	<p>Based on an observation with the Maintenance Supervisor on 09/09/16 at 2:30 p.m., the North Hall linen room door did self-close but failed to latch into the frame. The linen room contained numerous stacks of clean sheets, pillowcases, and towels for resident use. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All residents living in the health center have the potential to be affected by a similar type of deficiency. Nursing and housekeeping staffs have been educated on the correct procedure to complete a work order. Once a work order is established the maintenance staff has 24 hours to correct a deficiency of this type.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Housekeeping and nursing staffs were instructed to notify maintenance and put in a work order if the latch on any door does not work properly or they discover any other problems requiring repair.</p>	

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K 0054 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure all smoke detectors on the West Hall and the North Hall had been tested for sensitivity every two years. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, The National Fire Alarm Code. NFPA 72, at 7-3.2</p>	K 0054	<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>Housekeeping staff will check the linen closets latches when removing and stacking linens.</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>September 16, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The readings will be done by the vendor and put into the University Place preventive maintenance binder.</p>	09/30/2016

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	<p>requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(i) refers to 7-3.2.1 which requires Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test</li> </ol>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All residents in the health center have the potential to be affected by the deficiency. The vendor will take the readings to ensure the detectors are within the proper limits.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The University Plant Director will ensure all areas on the vendor's check sheet are complete and documented.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p>				

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	<p>methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the document "Annual / Quarterly Fire Alarm System Inspection" from Brenneco Fire Protection with the Plant Operations Tech III on 09/09/16 at 1:45 p.m., the most recent sensitivity testing record for the aforementioned smoke detectors was dated 07/27/16. A check of all documentation provided showed no listed range or trip point for any of the tested smoke detectors. Based on an interview with the Maintenance Supervisor and the Executive Director at the survey exit conference on 09/09/16 at 3:30 p.m., both acknowledged that the smoke detector sensitivity test did not contain all the above listed items.</p>		<p>Even though the readings are required every two years, each year when the vendor completes the readings and presents the check list to the Plant Director, the Plant Director will sit down with the vendor and ensure all readings are in compliance before accepting the paperwork.</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>September 30, 2016</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-19(b)				