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 08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	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
K 0000 Bldg. 01	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). Survey Date: 08/30/16 Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650 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. 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 Type III (200) construction and fully sprinklered. The facility has a fire alarm	K 0000	**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 or its management company that the allegations contained in the survey report is a true and accurate portrayal of the other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. In lieu of a post-survey revisit the community respectfully requests a desk review.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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 154 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage providing facility storage services. Quality Review completed on 09/02/16 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for			

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	keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors did not have an impediment to closing and latching. This deficient practice could affect 13 residents, staff and visitors in the 300 Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the corridor door to Room 302 failed to latch into the door frame because the latching mechanism failed to protrude into the latching plate. Based on interview at the time of observation, the Maintenance Director of Maintenance acknowledged the corridor door to Room 302 had an impediment to closing and latching into the door frame. 3.1-19(b)	K 0018	**I. The door stop was removed and the holes in the doors were caulked II. Full house inspection completed to ensure compliance. III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance and functionality. IV. Administrator/ Designee will audit systematic changes utilizing an audit tool monthly for six months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire			

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	resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the	K 0025	**I. Area by room 111 was fire caulked. II. All facility inspection of all areas to ensure compliance. III. Maintenance Supervisor/Designee will conduct inspections after vendors perform work to ensure proper caulking in smoke barriers. IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, three two inch in diameter open ended conduits containing cables penetrated the ceiling of the electrical room by Room 111 which were not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned holes in the ceiling smoke barrier did not maintain at least a one half hour fire resistance rating. 3.1-19(b)			
K 0038 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 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	K 0038	**I. The code has been posted to allow ready accessible. The door to the service hall was adjusted. II. All facility inspection of all areas to ensure compliance. III. Maintenance Supervisor/Designee will conduct monthly inspections to verify posting and weekly inspections to ensure functionality of door release. IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this**	09/29/2016

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	health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the entrance to the 300 Hall which was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code to release the exit door to open was not posted. Based on interview at the time of observation, the Maintenance Director stated the 300 Hall was a secured wing where all residents in the wing have a clinical diagnosis to be in a secure building and acknowledged the correct four digit code was not posted at the entrance to the 300 Hall. 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. 3.1-19(b) 2. Based on observation and interview,		**audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	

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	the facility failed to ensure the means of egress through 1 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 that 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 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			

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	stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the exit door into the service hall was marked as a facility exit and was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device but the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times. Based on interview at the time of observation, the Maintenance Director stated the aforementioned exit is a facility exit, is equipped with signage stating the exit door could be opened in 15 seconds by pushing on the release device but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times. 3.1-19(b)			

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K 0048 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 104 of 124 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect 134 residents, staff and visitors. Findings include: Based on review of "Disaster Manual"	K 0048	**I. An updated Battery Operated Smoke detector directive was added to the disaster manual. It includes staff response.** **II. All facility inspection of all disaster manuals reviewed to ensure compliance.** **III. Training will be given on 09/23 for staff to ensure understanding of their responsibility relative to smoke detectors. Maintenance Supervisor/Designee will conduct monthly inspections to ensure compliance.** **IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	and "Fire Disaster Plan" documentation with the Maintenance Director during record review from 9:05 a.m. to 11:25 a.m. on 08/30/16, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 104 of 124 resident sleeping rooms. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 104 resident sleeping rooms. 3.1-19(a)			
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement			

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	may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 2 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. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Direct Supply TELS Logbook Documentation: Fire Drills" documentation with the Maintenance Director during record review from 9:05 a.m. to 11:25 a.m. on 08/30/16, documentation for the third shift fire drill conducted on 03/31/16 at 6:30 a.m. and documentation for the first shift fire drill conducted on 07/29/16 at 7:20 a.m. each did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned third shift fire drill stated	K 0050	**I. Subsequent drills outside the hours of 9:00 p.m. -6::00 a.m. will include activation of the fire alarm system and transmission of the fire alarm signal.** **II. All facility inspection of all drills to ensure compliance.** **III. Maintenance Supervisor/Designee will update the fire drill schedule to verify all drills outside the areas of 9p-6a include activation of the fire alarm system and transmission of the fire alarm signal.** **IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	"Yes" in response to "did alarm company receive the signal from facility's alarm system" and stated "2:06 p.m." as the "time received." The third shift fire drill documentation also stated "residents still sleeping - did silent." Documentation for the first shift fire drill on 07/29/16 also stated the alarm company received the alarm signal but it was received at "1:31 p.m." Based on interview at the time of record review, the Maintenance Director stated the fire alarm system was not activated at the time of each of the two fire drills and acknowledged documentation for the aforementioned first and third shift fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. 3.1-19(b) 3.1-51(ac)			
K 0052 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,			

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	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on	K 0052	**I. The electrical cabinet panel was locked. II. All facility inspection of all electrical panels was completed to ensure compliance. III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	08/30/16, the fire alarm system breaker in the electrical cabinet by the main fire panel in the electrical room in the service hall was not enclosed in a locked or sealed cabinet. Based on interview at the time of observation, the Maintenance Director acknowledged the fire alarm system breaker was not enclosed in a locked or sealed cabinet. 3.1-19(b)			
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on observation and interview, the facility failed to ensure the remote manual stop for 1 of 1 emergency generators was provided with an alarm indicator and annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the	K 0144	**I. A light was installed on the annunciator panel to indicate the operation of the emergency or auxiliary power source.** **II. No other fire panels exist** **III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance and functionality.** **IV. Administrator/ Designee will audit systematic changes utilizing an audit tool monthly for six months. Results of this audit will be reviewed at the monthly**	09/29/2016

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 08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	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
	emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. [NFPA 110: 3-5.5.2] NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition, Section 1-3 states NFPA 110 applies to new installations of		**Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	

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	Emergency Power Supply System (EPSS). Section 3-5.5.2(d) requires battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). Table 3-5.5.2(d) states a remote emergency stop indicator for the shutdown of the emergency generator shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the emergency generator annunciator panel located near the east nurse's station was not provided with a remote stop indicator for shutdown of the emergency generator. The remote stop switch for the emergency generator was also located at the east nurses station. The emergency generator was located outside the facility near the electrical room exit from the service hall. Manufacturer's information affixed to the			

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	155327		08/30/2016

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	emergency generator indicated it was manufactured 03/24/10 and was rated at 70 kW. Based on interview at the time of observation, the Maintenance Director stated he was unaware if the remote stop at the east nurse's station would remain depressed if pushed not allowing the emergency generator to start and acknowledged the emergency generator annunciator panel located near the east nurse's station did not provide a visual an audible signal of system trouble for remote stop switch activation. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient	K 0147	**I. The refrigerator and microwave were plugged directly into an outlet and the power strip was removed.** **II. Full house audit performed to ensure compliance with regulation** **III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance. Administrator/ Designee will audit systematic changes utilizing an audit tool monthly for six months. Results of this audit will be reviewed at the monthly Quality Assurance**	09/29/2016

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	practice could affect 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the following was noted: a. a refrigerator and a microwave oven were plugged into a power strip in the Staff Development Office in the 100 Hall. b. a refrigerator and a microwave oven were plugged into a multiplug adaptor which was plugged into a wall outlet in Room 407. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip and a multiplug adaptor were being used as a substitute for fixed wiring in the aforementioned two locations. 3.1-19(b)		**Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in	K 0000	**This plan of correction is to serve as University Heights Health and Living Community's credible allegation of**	

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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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	accordance with 42 CFR 483.70(a). Survey Date: 08/30/16 Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650 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. This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202 was constructed in 2012 and was determined to be of Type V (111) 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 smoke detectors in all resident sleeping rooms in the 100, 200, 300, 400, 500, 600, 700 and 800 Hall. The facility		**compliance.** **Submission of this plan of correction does not constitute an admission by University Heights Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. In lieu of a post-survey revisit the community respectfully requests a desk review.**	

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	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 154 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage providing facility storage services.			
K 0018 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 3 of over 18 corridor doors did not have an impediment to closing and latching or would not resist the passage of smoke. This deficient practice could affect 18 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the	K 0018	**I. The door stop was removed and the holes in the doors were caulked II. Full house inspection completed to ensure compliance. III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance and functionality. IV. Administrator/ Designee will audit systematic changes utilizing an audit tool monthly for six months. Results of this audit will be reviewed at the**	09/29/2016

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	facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the following was noted: a. the corridor door to Speech Therapy was propped in the fully open position with a wedge placed on the floor. b. the corridor door to the women's restroom by Occupational Therapy and the corridor door to the restroom by the 900 Hall Mechanical Room each had two one and a half inch holes in the door above and below the door handle. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. 3.1-19(b)		**monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
K 0050 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			

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	Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 2 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. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Direct Supply TELS Logbook Documentation: Fire Drills" documentation with the Maintenance Director during record review from 9:05 a.m. to 11:25 a.m. on 08/30/16, documentation for the third shift fire drill conducted on 03/31/16 at 6:30 a.m. and documentation for the first shift fire drill conducted on 07/29/16 at 7:20 a.m. each did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned third shift fire drill stated "Yes" in response to "did alarm company receive the signal from facility's alarm	K 0050	**I. Subsequent drills outside the hours of 9:00 p.m. -6::00 a.m. will include activation of the fire alarm system and transmission of the fire alarm signal.** **II. All facility inspection of all drills to ensure compliance.** **III. Maintenance Supervisor/Designee will update the fire drill schedule to verify all drills outside the areas of 9p-6a include activation of the fire alarm system and transmission of the fire alarm signal.** **IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	system" and stated "2:06 p.m." as the "time received." The third shift fire drill documentation also stated "residents still sleeping - did silent." Documentation for the first shift fire drill on 07/29/16 also stated the alarm company received the alarm signal but it was received at "1:31 p.m." Based on interview at the time of record review, the Maintenance Director stated the fire alarm system was not activated at the time of each of the two fire drills and acknowledged documentation for the aforementioned first and third shift fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. 3.1-19(b) 3.1-51(ac)			
K 0052 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance	K 0052	**I. The electrical cabinet panel was locked. II. All facility inspection of all electrical panels was completed to**	09/29/2016

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	with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the fire alarm system breaker in the electrical cabinet by the main fire panel in the electrical room in the service		**ensure compliance. III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.IV. Administrator/Designee will audit systematic changes utilizing an audit tool monthly for 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	

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	hall was not enclosed in a locked or sealed cabinet. Based on interview at the time of observation, the Maintenance Director acknowledged the fire alarm system breaker was not enclosed in a locked or sealed cabinet. 3.1-19(b)			
K 0144 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on observation and interview, the facility failed to ensure the remote manual stop for 1 of 1 emergency generators was provided with an alarm indicator and annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate:	K 0144	**I. A light was installed on the annunciator panel to indicate the operation of the emergency or auxiliary power source.** **II. No other fire panels exist** **III. Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance and functionality.** **IV. Administrator/ Designee will audit systematic changes utilizing an audit tool monthly for six months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	09/29/2016

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	1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. [NFPA 110: 3-5.5.2] NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition, Section 1-3 states NFPA 110 applies to new installations of Emergency Power Supply System (EPSS). Section 3-5.5.2(d) requires battery-powered individual alarm indication to annunciate visually at the			

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	control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). Table 3-5.5.2(d) states a remote emergency stop indicator for the shutdown of the emergency generator shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:25 a.m. to 2:10 p.m. on 08/30/16, the emergency generator annunciator panel located near the east nurse's station was not provided with a remote stop indicator for shutdown of the emergency generator. The remote stop switch for the emergency generator was also located at the east nurses station. The emergency generator was located outside the facility near the electrical room exit from the service hall. Manufacturer's information affixed to the emergency generator indicated it was manufactured 03/24/10 and was rated at 70 kW. Based on interview at the time of observation, the Maintenance Director			

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	stated he was unaware if the remote stop at the east nurse's station would remain depressed if pushed not allowing the emergency generator to start and acknowledged the emergency generator annunciator panel located near the east nurse's station did not provide a visual an audible signal of system trouble for remote stop switch activation. 3.1-19(b)			