

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 10/09/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
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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: 10/09/14</p> <p>Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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 hard</p>	K010000	<p>University Place ("the Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. This POC should not be construed as an admission of any all alleged deficiency cited. The Provider submits the POC with the intention that it be inadmissible by any third party in any civil or criminal against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the provider determines that the disputed findings, (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS") the State of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 and the federal Rules of Evidence and should be inadmissible in any proceedings on that basis.</p>	
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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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K010018 SS=E	<p>wired smoke detectors in all resident sleeping rooms. The facility has a 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.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the</p>	K010018	K018	10/10/2014			

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K010050 SS=F	<p>facility failed to ensure 1 of 1 set of double leaf corridor doors on North hall could latch independently into their door frames. This deficient practice could affect 14 residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/09/14 at 12:00 p.m. with the Maintenance Supervisor, the set of double leaf corridor doors on North hall leading into the linen closet required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame.</p> <p>Based on interview on 10/09/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the aforementioned set of corridor doors would not latch independently into their door frame.</p> <p>3.1-19(b)</p> <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</p>		<p>Immediate Action Heley's Locksmith changed the North hall door latch to an independent latch system on 10/10/2014 Exhibit A</p> <p>Other Residents Affected No residents affected, no fires reported within the time frame identified</p> <p>Guard Against Reoccurrences Other double doors were tested within the same unit and found in working order with independent latches</p> <p>Monitoring of Compliance Double doors identified as broken or not latched will be brought to the attention of Plant Operations using the work order system. The Plant Operations Director will prioritize the repair as urgent and immediately correct or hire an outside vendor to correct. Inability to correct within twenty-four hours will be brought to the attention of the executive Director for immediate remedy.</p> <p>Compliance Date 10/10/2014</p>				

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	<p>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 ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 10/09/14 at 2:04 p.m. with Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months, from 10/2013 to 10/2014, indicated the fire alarm system had been activated, but the verification of the transmission of the signal was not documented. Based on interview on 10/09/14 at 2:05 p.m., it was acknowledged by Maintenance Supervisor none of the fire drill reports documented the transmission of the</p>	K010050	<p>K050</p> <p>Immediate Action</p> <p>Director of Plant Operations was educated on regulations regarding fire drills. Preliminary schedule of drills was made with a signal verification step. Exhibit B</p> <p>Other Residents Affected</p> <p>No residents were affected as drills commenced and training continued. Fire Drills with full alarms were conducted at 10PM on 10/21/2014 and 545AM on 10/22/2014. Signal response was validated by responding fire department.</p> <p>Guard Against Reoccurrence</p> <p>A schedule of fire drills was made that included alarm signal validation. Completed fire drills will be reported at daily managers meeting.</p> <p>Monitor of Compliance</p> <p>The fire drills will be reported quarterly at the QA Committee meeting. Any recommendations for additional monitoring will be determined by the Committee as warranted.</p> <p>Compliance date</p> <p>10/21/2014</p>	10/21/2014			

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K010051 SS=F	<p>signal was received by the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice</p>	K010051	<p>K051 Immediate Action The communication room door was labeled "Fire Alarm Circuit Control" The breaker panel cover was then labeled in red letters, "Fire Alarm Circuit Control".</p> <p>Other Residents Affected No residents were affected as no incidence required circuit control during the specified time period.</p> <p>Guard Against Reoccurrence</p>	10/21/2014

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K010070 SS=E	<p>could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/09/14 at 12:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the telephone room on Employee entrance hall lacked full identification. Inside the panel next to the fire alarm breaker was an unmarked piece of gray duct tape. Based on interview on 10/09/14 at 12:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters in non resident rooms. This deficient practice could affect any</p>	K010070	<p>The management team was informed of the labeling and instructed to locate it upon request of the fire department. The Plant Operations Director and Plant Operations staff were shown the labels as well. The labeling is permanent</p> <p>Monitoring for Compliance Plant Operations Director or designee will monitor that the labeling remains as part of the QA process. Any question or concern regarding labeling will be directed to the Plant Operations Director, Executive Director or Fire Marshall.</p> <p>Compliance Date 10/21/2014</p> <p>K070 Immediate Action Space heater was removed from the beauty salon Other Residents Affected The heater did not exceed 212</p>	10/10/2014			

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K010144 SS=F	<p>resident in the Beauty Salon as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/09/14 at 1:45 p.m. with the Maintenance Supervisor, a portable space heater which was not plugged in but available for use was located in the Beauty Salon on West Entrance hall. Based on interview on 10/09/14 concurrent with the observation, it was acknowledged by the Maintenance Supervisor space heaters were not allowed in the facility. The facility did not have a portable space heater policy for review to indicate they could not be used in non resident rooms unless the heating elements of the portable heater did not exceed 212 degree F.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than</p>		<p>degree capability nor was it plugged in for use. No residents affected</p> <p>Guard Against Reoccurrence The Managers on Duty were informed of the space heater regulation. Space heaters are not allowed in the building. Managers on Duty make daily rounds seven days a week and will monitor that no space heaters were introduced to the building.</p> <p>Monitoring for Compliance The Manager on Duty will note any space heater found and remove it. The Manager on Duty will alert the management team in daily standup meeting. Any questions or concerns will be directed to the Plant Operations Director and Executive Director for immediate remedy.</p> <p>Compliance Date 10/10/2014</p>				
			K010144	<p>K144 Immediate Action The generator was tested under load on 10/21/2014 and 10/22/2014. Other Residents Affected No residents were affected as the generator functioned with in normal limits Guard Against Reoccurrence Plant Operations</p>	10/21/2014		

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	<p>30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 10/09/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate</p>		<p>staff were inserviced by ADDCO, generator specialist on 10/30/2014. The plant operations staff will perform weekly inspections and monthly test under load as instructed by ADDCO. ADDCO provided written instructions for the procedure. Exhibit D Monitoring for Compliance Any generator failure by procedure or indicated by control panel will be forwarded to the Plant Operations director and/or Executive Director for immediate remedy. ADDCO will provide annual generator testing and full maintenance.</p> <p>Compliance Date 10/21/2014</p>				

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	<p>rating and no other method was used to document monthly load for the past twelve months. Based on interview on 10/09/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly and was aware it had to be documented at 30 percent but could not verify the percentage and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power</p>			

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K010154 SS=F	<p>source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of Generator Log records on 10/09/14 at 3:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load was not documented. Based on interview on 10/09/14 at 3:33 p.m. with the Maintenance Supervisor it was acknowledged the information on time of load transfer had not been recorded for the past twelve months and the Maintenance Supervisor was unaware it needed to documented.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 19 of 19</p>	K010154	<p>K154 Immediate Action A fire watch policy has been located</p>	10/30/2014

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	<p>residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on Sprinkler record review on 10/09/14 at 3:25 p.m., with the Maintenance Supervisor the facility did have a written policy and procedure for</p>		<p>and is available in the policy handbook. The Plant Operations Director and Executive Director acknowledged the understanding of the policy for implementation if needed. The policy includes notification of the monitoring agency, local fire authority notified and the commencement of a fire watch. Exhibit E 1-3</p> <p>Other Residents Affected No residents were affected as there were no incidences requiring such notification or disruption of fire sprinkling service during this specified time.</p> <p>Guard Against Reoccurrence Any utility disruption, fire panel alarm or utility disruption initiates notification to the Plant Operations Director and the Executive Director. A Director would notify the fire monitoring agency and confer with the responding West Lafayette Fire Department Battalion Chief. The Director would instruct the implementation of a fire watch by on-sight instruction with a written log book until correction action is complete.</p> <p>Monitor for Compliance Any disruption of sprinkler service would have been called to the Directors as outlined. Notification of local fire agencies and fire monitoring agency would have been completed based on automatic monitoring alarms of "trouble to service". The reporting would also constitute an occurrence report to</p>	

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K010155 SS=F	<p>an impaired sprinkler system available for review, but it did not address notifying the Insurance Carrier, Owner/Operator and Monitoring company and then notify all six entities again once the sprinkler system has been restored to normal. Based on interview on 10/09/14 at 3:26 p.m. with the Maintenance Supervisor, it was acknowledged the fire watch policy did not include notifying the aforementioned entities and once again when the sprinkler system had been restored to normal operation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written fire watch policy in the event the fire alarm system is out of service for more than 4 hours in a 24 hour period for the protection of 19 of 19 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the</p>	K010155	<p>the Indiana State department of Health. The Indiana State department of Health would review the occurrence report and/or visit the community for survey/investigation. Any and all of these processes initiate internal audits from the Quality Assurance and Safety committees as well as Corporate Compliance Officer.</p> <p>Compliance Date 10/30/2014</p> <p>K155 Immediate Action A fire watch policy has been located and is available in the policy handbook. The Plant Operations Director and Executive Director acknowledged the understanding of the policy for implementation if needed.</p> <p>Other Residents Affected No residents were affected as there</p>	10/30/2014

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 10/09/2014	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906			
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	<p>protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on Fire Alarm record review on 10/09/14 at 3:37 p.m., with the Maintenance Supervisor, the facility did have a written policy and procedure for an impaired fire protection system available for review, but it did not address notifying the Insurance carrier, Owner/Operator and Monitoring company and then notifying everyone again when the system is restored. Based on interview on 10/09/14 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged the fire watch policy did not include the aforementioned entities and did not disclose notifying all entities again once the system had been</p>		<p>were no incidences of fire watch need during the specified period.</p> <p>Guard Against Reoccurrence Any utility disruption or fire panel alarm initiates notification to the Plant Operations Director and the Executive Director. Each Director would instruct the implementation of a fire watch by onsite instruction with a written log book. Such occurrence would be reported through the Quality Assurance and safety Committee.</p> <p>Monitor for Compliance Any disruption of utility last four or more hours would have been called to the Directors as outlined. The reporting would also constitute an occurrence report to the Indiana State department of Health. The Indiana State department of Health would review the occurrence report and/or visit the community for survey/investigation. Any and all of these processes initiate internal audits from the Quality Assurance and Safety committees as well as Corporate Compliance Officer.</p> <p>Compliance Date 10/30/2014</p>				

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

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	restored. 3.1-19(b)				