

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 11/14/2013
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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: 11/14/13</p> <p>Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890</p> <p>Surveyor: Bridget Brown, 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 Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility located on the first floor on one wing of a two story building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in spaces open to the</p>	K010000	<p>University Place ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action 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, or for any increase in 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 of the Federal rules of Evidence and should be inadmissible in any proceeding 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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	<p>corridors. The facility has the capacity for 30 and had a census of 28 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/20/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K010025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 5 of 5 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient practice could affect visitors, staff and all residents.</p> <p>Findings include:</p>	K010025	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? All ceiling and wall penetrations have been corrected using proper Fire Protection Products. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? a. This deficiency will be corrected using firestopped assembly F-C-3017 (copy attached) as it applies to the ceiling portion of the detail, and the associated 3M Fire Protection Products. b. This deficiency will be corrected by first removing the existing	12/11/2013			

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	<p>Based on observation with the Director of Plant Operations on 11/14/13 between 12:00 p.m. and 3:30 p.m., the following ceiling and wall penetrations were found:</p> <p>a. Unsealed half inch holes in resident room closet ceilings for the passage of wire in all 30 resident rooms;</p> <p>b. Sealed with expandable foam in the smoke barrier above the lay in ceiling near physical therapy by two, four inch pipes for the passage of wire bundles;</p> <p>c. Unsealed half inch gaps in the wall above the lay in ceiling of the Human Resources office, part of the smoke barrier, by two, six inch pipes;</p> <p>d. Unsealed half inch gap around a two inch sprinkler pipe in the smoke barrier between health care and the service corridor above the lay in ceiling;</p> <p>e. Unsealed one inch gap around the four inch pipe through the smoke barrier between the service corridor and health care above the lay in ceiling;</p> <p>f. Unsealed, a one fourth inch annular gap at the sprinkler pipe in the corridor wall of the health care storage room near the service corridor smoke barrier;</p> <p>g. Unsealed, a three fourths inch gap</p>		<p>expandable foam material, and then packing the existing sleeve with 3M Fire Protection Products "Fire Barrier Moldable Putty +" (see attached product data sheet). c. This deficiency will be corrected following the UL 311 assembly for sealing joints in 1 HR rated smoke partitions. d. This deficiency will be corrected using firestopped assembly W-L-1167 (copy attached), and the associated 3M Fire Protection Products. e. This deficiency has been corrected. f. This deficiency has been corrected. g. This deficiency has been corrected. h. This deficiency has been corrected. i. This deficiency will be corrected using firestopped assembly F-C-2039 (copy attached) as it applies to the ceiling portion of the detail, and the associated 3M Fire Protection Products. - how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur?</p> <p>The Director of Plant Operations, or Designee, will monitor weekly x3 weeks then quarterly, or sooner if needed, x2 quarters. Results of the on-going monitoring will be reviewed in the monthly QAPI meeting for action.</p>				

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	<p>around the six inch duct in the smoke barrier above the lay in ceiling near the kitchen;</p> <p>h. Unsealed, one half to one inch gap along one side of the attic access panel in the west wing janitor's closet where the frame was missing;</p> <p>i. Unsealed, one fourth inch annular gap in the corridor ceiling outside the kitchen where the escutcheon was missing from the sprinkler head.</p> <p>The Director of Plant Ops acknowledged at the time of observations, the unsealed penetrations and those sealed with expandable foam.</p> <p>3.1-19(b)</p>				

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K010029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic closers for doors providing access to 2 of 10 hazardous areas such as a combustible materials storage room larger than 50 square feet and a maintenance shop. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors and 10 or more staff in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 between 2:10 p.m. and 2:25 p.m., doors separating the twelve by twelve foot linen supply storage room and the maintenance shop from the service area corridor each had no self</p>	K010029	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? New self-closing devices have been installed on each of the doors. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? New self-closing devices will be installed on each of the doors. The devices will be consistent with the UL fire rating of both the door and frame.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not	12/14/2013	

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	closing device. The Director of Plant Ops said at the time of observations, he didn't know doors to the rooms were required to self close. 3.1-19(b)		recur? The Director of Plant Operations, or Designee, will monitor weekly x3 weeks then quarterly, or sooner if needed, x2 quarters. Results of the on-going monitoring will be reviewed in the monthly QAPI meeting for action.		

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K010046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors and 3 or more maintenance staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/113 at 1:50 p.m., the battery powered emergency lighting provided for the electrical room housing electric circuit panels and emergency generator transfer switches failed to illuminate when tested twice. The maintenance director said at the time of observation, he did not know the light was not working</p> <p>3.1-19 (b)</p> <p>2. Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 1 of 1 battery powered emergency lighting fixtures.</p>	K010046	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Battery powered emergency lighting has been replaced. A written record of appropriate testing has been put into practice. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? 1. This deficiency has been corrected. The battery powered emergency lighting in the Electrical Room is now functioning according to the requirements of LSC 7.9.2.5. 2. This deficiency has been corrected. Battery powered emergency lighting fixtures have been tested, and a written record of such tests will be maintained according to LSC 7.9.3.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or Designee, will	12/14/2013			

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	<p>LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice affects visitors and 3 or more maintenance staff.</p> <p>Findings include:</p> <p>Based on review of facility preventive maintenance inspection and test records with the Director of Plant Ops on 11/14/13 at 3:30 p.m., no record was found for monthly and annual testing for the battery powered emergency lighting provided in the emergency generator transfer switch room. The Director of Plant Ops said at the time of record review, he had not checked the fixture and was unaware of the requirement for documenting and performing the tests.</p> <p>3.1-19(b)</p>		<p>monitor monthly. Results of the on-going monitoring will be reviewed in the monthly QAPI meeting for action.</p>		

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 4 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Documentation and interview with the Director of Plant Ops on 11/14/13 at 3:15 p.m., there was one record of a fire drill conducted during the second shift on 11/04/13. Every other fire drill record was specific for areas other than health care and the Director of Plant Ops said these records accurately reflected the drills which had been done. Health care staff did not respond if drills were conducted in other occupancies in the building. He said drills were not done on the health care side to avoid disturbing</p>	K010050	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Fire drills have been completed on all three shifts. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency has been corrected. Fire drills will occur at unexpected times under varying conditions, at least quarterly on each shift, and a record of such drills will be maintained.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? Results of quarterly fire	11/15/2013	

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	residents. 3.1-9(b) 3.1-51(c)		drills will be submitted to the monthly QAPI meeting for monitoring and action.		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler 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 combustible canopies attached to the building exterior. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice affects visitors, staff and 10 or more residents who might use the courtyard.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 at 1:30 p.m., a 30 by 15 foot pergola of wood construction covered discharge to the courtyard from the health care dining room. The structure was attached to the building and was not protected by sprinklers. The</p>	K010056	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? This deficiency will be corrected by the complete removal of the existing pergola. This will be completed as soon as possible when outside weather conditions allow for safe removal. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency will be corrected by the complete removal of the existing pergola.	12/31/2013			

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	Director of Plant Ops said at the time of observation, he did not know sprinkler protection was required. 3.1-19(b)		Since this work is weather dependent, we anticipate completing this task by December 31, 2013.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? compliance with this alleged deficiency will be achieved through the removal of the pergola. on-going monitoring will not be needed.		

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to perform weekly sprinkler system fire pump tests. NFPA 25, 5-3.2.1 requires a weekly test of electric motor driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of the facility sprinkler system Weekly Fire Pump Test Log with the Director of Plant Ops on 11/14/13 at 4:10 p.m., no evidence of weekly fire pump maintenance testing was found since the last recorded date of 09/02/13. The Director of Plant Ops acknowledged at the time of record review, records for the weekly test were incomplete.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler</p>	K010062	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Weekly fire pump tests have been performed, and a weekly fire pump testing log is being maintained at all times to illustrate the test results. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? 1. This deficiency will be corrected according to the requirements of NFPA 25, 5-3.2.1. Weekly fire pump tests will be performed, and a weekly fire pump testing log will be maintained at all times to illustrate the test results. 2. This deficiency will be corrected. The existing ductwork will be removed from the sprinkler pipe, and will be hung from the structure independent of any fire sprinkler equipment.- how the	12/14/2013			

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	<p>pipng for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 at 12:45 p.m., a sprinkler pipe in the exit corridor above the lay in ceiling near physical therapy was used to support the weight of a flexible ventilation duct. The duct was indented by it's weight upon the pipe. The maintenance director agreed at the time of observation, sprinkler pipes were not for this purpose.</p> <p>3.1-19(b)</p>		<p>corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or designee, will test and document the testing each week. Results will be reviewed by the facility QAPI committee monthly.</p>		

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K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to provide 1 of 1 transfer switch room portable fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, and 2 or more maintenance staff.</p>	K010064	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Fire extinguisher replaced. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency has been corrected. The fire extinguisher has been examined, and a "Verification of Service Collar" has been installed according to NFPA 10, 4-4.4.2. - how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or designee, will monitor all fire extinguishers weekly x3 weeks then monthly thereafter. results will be reviewed by the facility QAPI committee.</p>	11/27/2013			

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	<p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 at 1:50 p.m., the portable fire extinguisher located in the emergency generator electrical transfer switch room lacked a verification of service collar. The extinguisher was stamped with a 2003 manufacture date. The Director of Plant Ops acknowledged at the time of observation, the date reflected a ten year lapse with nothing to identify a six year service had been done.</p> <p>3.1-19(b)</p>				

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K010068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and 10 or more residents in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 at 1:55 p.m., the laundry room had two gas fueled dryers with no fresh air intake. The Director of Plant Ops acknowledged at the time of observation, the two gas fueled dryers did not have a fresh air intake.</p> <p>3.1-19(b)</p>	K010068	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? This deficiency will be corrected by adding a fresh air intake to laundry room. This will be completed as soon as possible when outside weather conditions allow for safe installation - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency will be corrected according to the requirements of NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b). A fresh air intake (make-up combustion air) will be installed in the Laundry Room.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? compliance with this alleged deficiency will be achieved through the installation of a fresh air intake. on-going monitoring will not be needed.	12/31/2013			

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to provide the minimum protection between 2 of 2 commercial cooking appliances in the kitchen. NFPA 96, 9-1.2.3 requires deep fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment except where a steel or tempered glass baffle plate is installed at a minimum of eight inches in height between the adjacent appliances. This deficient practice could affect 4 kitchen staff and any visitors.</p> <p>Findings include:</p> <p>Based on observation of the commercial cooking appliances in the kitchen with the Director of Plant Ops on 11/14/13 at 2:45 p.m., the minimum separation of 16 inches or separation by an eight inch steel or tempered glass baffle plate was not provided between the gas range and fryer which were located side by side. The Director of Plant Ops said at the time of observation, he was unaware of the separation requirement.</p> <p>3.1-19(b)</p>	K010069	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?The fryer was seperated by 16 inches to meet the requirements of NFPA 96, 9-1.2.3. - how other residents having the potential to be affected by the same allegeddeficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency will be corrected according to the requirements of NFPA 96, 9-1.2.3. The fryer will be relocated away from the gas range.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? once fryer is relocated on-going monitoring is not needed.	12/14/2013			

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning and replacement of hard wired smoke detectors with battery back up in 30 of 30 resident sleeping rooms. LSC 4.6.12.2 requires any like safety code features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect visitors, staff, and all residents.</p> <p>Findings include:</p> <p>Based on review of the facility preventive maintenance records and the fire system contractor's Smoke Detector Sensitivity records with the Director of Plant Ops on 11/14/13 at 4:20 p.m., a sensitivity test was not documented for the hard wired resident room smoke detectors in the sensitivity report dated 10/31/13. The Director of Plant Ops said these detectors had battery back up and signaled to the panel at the nurse's station. They were not designed to be sensitivity tested. He said there was no monthly check or cleaning procedure maintained for the detectors and he changed batteries as the</p>	K010130	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? All resident room smoke detectors have been cleaned, sensitivity tested and had batteries checked. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency will be corrected according to the requirements of LSC 4.6.12.2. The resident room smoke detectors will be checked and cleaned monthly to ascertain that they are in good operating condition, and this work along with battery changes will be documented. - how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or designee, will monthly check batteries, clean, and test sensitivity of smoke detectors. documentation of this monitoring will be reviewed at the	11/27/2013	

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	alarms indicated their failure. No documentation for this was kept. He said he could not provide any written evidence that a battery check or regular cleaning procedure was not required to maintain the detectors in good operating condition. 3.1-19(a)		monthly facility QAPI meeting.		

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K010144 SS=F	<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>Based on record review and interview, the facility failed to ensure documentation of monthly generator tests for 1 of 1 emergency generators was completed to reflect the transfer of load using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that 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. NFPA 99,</p>	K010144	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?The generator was tested and kilowatts are being recorded in compliance with NFPA 99. - how other residents having the potential to be affected by the same allegeddeficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency has been corrected. Find attached an inspection, performance, and exercising log of the emergency generator that documents testing in accordance with NFPA 99.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or designee, will monthly conduct a load test on the generator and results will be documented according to NFPA 99. results will be reviewed at the facility QAPI monthly meeting.	11/18/2013			

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	<p>3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator Check Lists for the past year with the Director of Plant Ops on 11/14/13 at 4:15 p.m., the generator test documentation for weekly generator runs and monthly generator load tests reflected the same readings during the generator's operation. The Director of Plant Ops said at the time of record review, the load testing was conducted monthly and he just wrote "Load" on the date for the load documentation. He could not identify the percentage of load carried during the test and there were no readings recorded in the documentation to indicate a change in the load during the test. He did not know how to calculate the percentage of load carried. He said he "pushed the button on the generator for three seconds and the generator started." He said the preventive maintenance contractor had conducted a load bank test. A review of the contractor's 09/25/13 Annual Preventive Maintenance check evidenced the generator had run but there</p>						

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	<p>was nothing to indicate a load bank test was done.</p> <p>3.1-19(b)</p>			

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure an electrical equipment room in 2 of 5 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors and 10 or more staff in the room and adjacent service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 at 1:50 p.m., an electrical room housing three electrical circuit panels and a bank of emergency generator transfer switches was accessed through doors from the service corridor and the laundry. The room was used to store a straight back chair, Housekeeping cart, wheelchair and empty mobile clothes</p>	K010147	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Clutter in these rooms was immediately cleared out. - how other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? 1. This deficiency has been corrected. The Electrical Room has been cleared of all stored items in order to maintain required clearances according to NFPA 70. 2. This deficiency has been corrected. The flexible cords and multi tap adapters have been removed.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant Operations, or designee, will inspect rooms weekly and document the inspections. results of these inspections will be reviewed in the facility QAPI monthly meeting.	11/18/2013			

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	<p>rack. The stored equipment abutted the bank of transfer switches and circuit panels. The Director of Plant Ops acknowledged at the time of observation, the electrical equipment was not readily accessible to maintenance staff.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure flexible cords and multi tap adapters were not used as a substitute for fixed wiring in 2 of 30 resident rooms and 1 of 1 dietary offices. NFPA 70, the National Electrical Code, 1999 Edition, 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 affect kitchen staff, visitors and 2 residents in rooms 1107 and 1127.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/14/13 between 12:15 p.m. and 3:45 p.m., a multi tap adapter was used to power a refrigerator and other electric equipment in resident room 1107. An extension cord under the resident's bed in room 1127 and one in the kitchen dietary office provided power to electric equipment. The Director of Plant Ops</p>				

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	said at the time of observations, he didn't know this supply for electricity should not have been in use. 3.1-19(b)			

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 11/14/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906			
(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			
K010154 SS=F	<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 observation and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 28 of 28 residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 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. NFPA 25, A-11-5(c)2 states, "a fire watch should consist of trained personnel who continuously patrol</p>	K010154	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?The policy was implemented and staff training is on-going. - how other residents having the potential to be affected by the same allegeddeficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency has been corrected. Find attached our written policy in accordance with the LSC, containing procedures to be followed to protect the residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not	11/18/2013			

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	<p>the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy provided as evidence of procedures to follow in the event the automatic sprinkler system was out of service with the Director of Plant Ops on 11/14/13 at 3:05 p.m., the policy was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the automatic sprinkler system is out of service for four hours in a twenty four hour period, notice to the fire department and ISDH and the documentation of the fire watch tour every fifteen minutes. The Director of Plant Ops acknowledged at the time of record review, the policy did not spell out procedures to be followed.</p> <p>3.1-19(b)</p>		<p>recur? The Director of Plant Operations will provide on-going training to staff on the fire watch policy and procedures. any problems or concerns will be monitored monthly at the facility QAPI meeting.</p>		

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K010155 SS=F	<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 observation and interview the facility failed to provide a complete written policy containing procedures to be followed to protect 28 of 28 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect staff, visitors, and all residents.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy provided as evidence of procedures to follow in the event the fire alarm system was out of service with the Director of Plant Ops on 11/14/13 at 3:05 p.m., the policy was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period, notice to the fire department and ISDH and the documentation of the fire watch tour every fifteen minutes. The</p>	K010155	- what corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?The policy was implemented and staff training is on-going. - how other residents having the potential to be affected by the same allegeddeficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? This deficiency has been corrected. Find attached our written policy in accordance with the LSC, containing procedures to be followed to protect the residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period.- how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur? The Director of Plant	11/25/2013			

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	Director of Plant Ops acknowledged at the time of record review, the policy did not spell out procedures to be followed. 3.1-19(b)		Operations will provide on-going training to staff on the fire watch policy and procedures. any problems or concerns will be monitored monthly at the facility QAPI meeting.		