STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155725	A. BUILDING -- B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/16/24 Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890 At this Emergency Preparedness survey, University Place Health Center and Assisted Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 30 certified beds. At the time of the survey, the census was 27. Quality Review completed on 12/18/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/16/24 Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890 At this Life Safety Code survey, University Place	K 0000	University Place corrected the Life Safety violations the same day as the inspection. University Place held an in-service regarding one of the violations a week later. University Place has answered the questions for each violation and submitted pictures to show the corrections as well as the agenda for the All-Staff Meeting on December 23.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David M. Kinder	Executive Director	12/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Health Center and Assisted Living was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility is located on the first floor on one wing of a two-story building and was determined to be of Type V (111) construction and was sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 30 and had a census of 27 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the overhang located outside the northeast exit. Quality Review completed on 12/18/24		University Place feels a Desk Review is in order.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 2 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the	K 0211	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Wheels were put on the dressers to be able to move them whenever necessary on December 16, 2024. At the All-Staff Meeting December 23, 2024, the staff was educated on the importance of the wheels in case of an emergency.	12/23/2024

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	wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations on 12/16/24 between 12:18 a.m. and 1:41 p.m. during a tour the facility, the following was noted: a) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1120 that contained personal protective equipment (PPE) and was not on wheels. b) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1123 that contained PPE and was not on wheels. c) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1124 that contained PPE and was not on wheels. d) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1125 that contained PPE and was not on wheels. e) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1129 that contained PPE and was not on wheels. f) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1130 that contained PPE and was		**2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Any resident exiting a door during a fire could be affected by the immobility of the drawers. Wheels were put on all the drawers on December 16, 2024, and the staff was educated on importance of the wheels in the case of an emergency during the All-Staff Meeting on December 23. **3 What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** The Plant team was told to only purchase dressers with wheels already in place in the future. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Plant staff will purchase only dressers with wheels attached and angel round managers will look at the dressers weekly to ensure the wheels are still on the dressers. **5 By what date the**	

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	not on wheels. g) There was a small three drawer plastic dresser located in the corridor between resident rooms #1101 and resident room #1102 that contained PPE and was not on wheels. h) There was a small three drawer plastic dresser located in the corridor between resident rooms #1103 and resident room #1104 that contained PPE and was not on wheels. i) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1105 that contained PPE and was not on wheels. j) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1108 that contained PPE and was not on wheels. k) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1109 that contained PPE and was not on wheels. l) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1110 that contained PPE and was not on wheels. m) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1115 that contained PPE and was not on wheels. n) There was a small three drawer plastic dresser located in the corridor immediately outside resident room #1116 that contained PPE and was not on wheels. Based on interview with the Director of Plant Operations at the time of the observations, he acknowledged the small three drawer plastic dressers were not on wheels adding that staff knows these items need to be on wheels and that he felt an in-service refresher training would need to be held to remind them of this requirement.		**systematic changes for the deficiency will be completed?** December 23, 2024.	

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	This item was discussed at the exit conference with the Director of Plant Operations on 12/16/24 at 1:50 p.m. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 2 of 25 resident room corridor doors contain decorations that did not exceed 30 percent of the door. LSC 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4) The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not	K 0753	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Christmas decorations on the doors were removed on December 16, 2024. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** When putting decorations on doors one of two things will be done: Only 70 percent or less of the door space will be used, or a flame-retardant spray will be used on the decorations before they are hung on the doors. **3 What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** The staff will only be allowed to	12/16/2024

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	protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 14 residents, 6 staff and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations on 12/16/24 between 12:18 a.m. and 1:41 p.m. during a tour the facility, the following was noted: a) The corridor door of resident room #1104 contained plastic and paper decorations and an artificial balloon that covered 100% of the door. b) The corridor door of resident room #1118 contained plastic and paper decorations that covered 100% of the door. Based on interview at the time of the observation, the Director of Plant Operations agreed the corridor doors were covered with a combustible decoration, stated the door was indeed 100% covered, and stated that he had not sprayed or treated these decorations with any flame-retardant, adding that staff was holding a door decorating contest for the residents. This item was discussed at the exit conference with the Director of Plant Operations on 12/16/24		decorate 70 percent of any resident door in the future. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Angel round managers were educated to the amount of any resident door that could be decorated. **5 By what date the systematic changes for the deficiency will be completed?** December 16, 2024.	

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	at 1:50 p.m. 3.1-19(b)			