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	01/03/2024

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: 01/03/24 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 23. Quality Review completed on 01/08/24	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: 01/03/24 Facility Number: 003673 Provider Number: 155725 AIM Number: 200450890 At this Life Safety Code survey, University Place	K 0000	University Place acknowledges a need to correct two items from the Life Safety Survey conducted on January 3, 2024. Because of the nature of the actions and the fact both areas have been corrected, University Place requests paper compliance or a desk review. Pictures of the work are attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Kinder	Executive Director	01/19/2024

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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 23 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 01/08/24			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 9 of 12 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Director of Plant Operations during a tour of the facility on 01/03/24 at 12:02 p.m., the facility has a supervised dry and wet sprinkler systems and had a total of twelve water and air pressure gauges. The manufacture date on nine of the 12 gauges was 2018 and was listed on the face of each expired sprinkler system gauge. No recalibration date information was affixed to the sprinkler system gauges either. Based on interview at the time of the observations, the Director of Plant Operations stated he did not believe sprinkler system gauges had been recalibrated within the most recent five-year period and acknowledged that documentation of sprinkler system gauge replacement or recalibration was not available for review for each of the 9 sprinkler system gauges	K 0353	**1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice?** The corrective action is to re-inspect and recalibrate the gauges and have proper dates showing the dates re-inspected on the gauges show the month, day and year inspected in 2024. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Because the gauges were not inspected within the five-year period there was a chance the gauges would not perform properly, which could affect all 30 rooms of the Health Center. 3. **What practices will be put into place and what systemic changes will be made to ensure that the deficient practices does not recur?** The gauges were re-inspected and calibrated by Brenneco on January 17, 2024. The Plant Department reminded Brenneco of the failure to test the equipment and logged the dates of all 12 gauges in question to be reviewed annually.	01/17/2024

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	which were all more than five years old. This finding was reviewed with the facility Administrator, the Director of Nursing, the Director of Plant Operations, and the Administrator-in-Training during the exit conference on 01/03/24 at 2:10 p.m. 3.1-19(b)		4. **/b>**How will corrective actions be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Plant Operations team will monitor the gauges upon each annual inspection by contractors in the future to ensure the gauges are re-inspected, calibrated and if needed be replaced and all gauges will show the correct year of the inspection. 5. **/b>**By what date will be systemic changes be made. All gauges in question were re-inspected and calibrated on January 17, 2024 by Brenneco. A picture with the 1/17/2024 date is included.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 24 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately as many as 15 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Director of Plant Operations on 01/03/24 at 1:46 a.m., the corridor door to resident room #1129 failed to close and latch into the frame. Based on interview at the time of observations, the Director of Plant Operations stated that he was not aware that the door would	K 0363	**1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice?** The corrective action is to replace the door handle to ensure the door closes properly. 2. **/b>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Anyone located in one of the 30 rooms on the Health Center could be potentially affected if their door handle was broken and the door	01/04/2024

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	not close and latch into the frame adding that he would have it looked at as soon as possible. This finding was reviewed with the facility Administrator, the Director of Nursing, the Director of Plant Operations, and the Administrator-in-Training during the exit conference on 01/03/24 at 2:10 p.m. 3.1-19(b)		would not close properly. The Plant staff inspected all of the other handles and none were deficient. 3.**/b>**What practices will be put into place and what systemic changes will be made to ensure that the deficient practices does not recur? This was the door handle identified as deficient and the only door in the Health Center that would not close. 4. **How will corrective actions be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** The nursing staff are in and out of the rooms daily. The nurses will monitor the potential problem and put in a work order if a handle is found to be deficient. The door handle was corrected. No quality assurance will be necessary. 5. **1 By what date will be systemic changes be made?** The door handle was corrected on January 4, 2024. A picture is included.	