STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING -- B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/22 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 At this Emergency Preparedness survey, University Nursing Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 75 and had a census of 62 at the time of this survey. Quality Review completed on 12/05/22	E 0000	University Nursing Center is alleging compliance on 1.3.23 and is requesting paper compliance for the annual life safety code recertification and state licensure survey.	
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: 12/05/22 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 At this Life Safety Code survey, University Nursing Center was found not in compliance with Requirements for Participation in	K 0000	University Nursing Center is alleging compliance on 1.3.23 and is requesting paper compliance for the annual life safety code recertification and state licensure survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Moore	Executive Director	12/19/2022

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	Medicare/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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility had a storage shed of maintenance supplies that was not sprinklered. Quality Review completed on 12/05/22			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview the facility failed to ensure the replacement for 45 of 45 battery operated smoke alarms were conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA	K 0300	**K 300 Protection - Other** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · - Expired battery operated	01/03/2023

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	72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director and Administrator on 12/05/22 at 9:42 a.m., the manufacturer's published instructions for the smoke alarms stated, "replace unit within 10 years of installation date." The date recorded on back of smoke alarm was 04/21/12. Based on interview at the time of records review, the Maintenance Director agreed the smoke alarms were in use over ten years and stated new smoke alarms will be installed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		smoke alarms have been removed and disposed of. · - 45 of 45 battery operated smoke alarms have been labeled with install date, tested and installed. 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; · All residents have the potential to be affected by the deficient practice. · Audit was completed of all battery operated smoke alarms to ensure all have been inspected, tested and are maintained per manufacturer's instructions with no additional concerns noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · - Maintenance/designee will round monthly to ensure all battery operated smoke alarms are in compliance. · - Battery operated smoke alarms due for replacement the following month will be replaced during monthly rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	

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			place; · - Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · - CQI tool identified Battery Operated Smoke Alarms will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · - If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 1/3/23 Paper Compliance is requested.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 9 manual fire alarm boxes (pull stations) were not obstructed. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70,	K 0345	**K 345 Fire Alarm System – Testing and Maintenance** What corrective action(s) will be accomplished for those residents found to have been affected by the	01/03/2023

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	National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72 2010 edition 17.14.5 states manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/05/22 at 11:30 a.m., the pull station in the dining hall had a cart and wheelchair in front of the pull station and was obstructed from direct access. Based on interview at the times of observation, the Maintenance Director agreed the pull station was blocked from access and removed the items in front of the pull station. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		deficient practice; · - Items immediately removed from in front of pull station 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; · All residents have the potential to be affected by the deficient practice. · Audit was completed of all manual fire alarm boxes (pull stations) and no additional obstructions were noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · - All Staff in-service to be completed by 1/3/23 per ED on not obstructing pull stations. · -- Maintenance/designee to round daily to ensure pull stations are not obstructed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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			· CQI tool identified Fire Alarm System will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 1/3/23 Paper compliance is requested.	
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 _____ 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			

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	#1) Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the housekeeping closet, 2 of 3 sprinklers in the 200-hall Spa, and 1 of 10 sprinklers in the kitchen were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director and the Administrator on12/05/22 between 10:30 a.m. and 12:00 p.m., the following sprinkler heads showed signs of corrosion: a) The sprinkler in the housekeeping closet. b) The two sprinklers in the 200-hall Spa by the showers. c) The sprinkler above the dishwasher in the kitchen. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned sprinkler heads showed signs of corrosion. #2) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers and a secure spare sprinkler cabinet large enough to fit all spare sprinkler heads. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**K 353 Sprinkler System – Maintenance and Testing** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Corroded sprinklers in housekeeping closet, 200-hall spa and kitchen dish area are in process of being replaced by sprinkling company vendor. · Spare sprinkler heads (quick response) x 4 and sprinkler cabinet large enough to hold spares have been ordered and will be installed upon arrival. · Cabinet will be installed securely to wall upon arrival. 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; · All residents have the potential to be affected by the deficient practice. · Maintenance will conduct a full audit of all sprinklers on premises to ensure that none are showing signs of corrosion. · If any are noted to show signs of corrosion, they will be immediately replaced. What measures will be put into place or what systemic changes will be made to ensure that the	01/03/2023

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Maintenance Director and Administrator on 12/05/22 at 10:51 a.m., the following was observed: a) The spare sprinkler cabinet in the riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in riser room was opened, the cabinet contained more sprinkler heads than spots available. b) The spare sprinkler cabinet in the riser room was not properly secured to the wall, was loose and was hanging at an angel. c) The facility contained quick response sprinklers in the resident rooms and all halls. There were no spare quick response sprinklers in the spare sprinkler cabinet. Based on interview at the time of the observations, the Maintenance Director and Administrator agreed the cabinet was not large enough to contain all spare sprinkler heads, the spare sprinkler cabinet was not properly secured and there were no spare quick response		deficient practice does not recur; · Maintenance/designee will round weekly to ensure all sprinkler heads are free from corrosion. · If any are noted to show signs of corrosion, they will be immediately replaced. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified Sprinkler System Maintenance will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 1/3/23 Paper compliance is requested.	

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	sprinklers. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 15 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/05/22 between 10:30 a.m. and 11:30 a.m., the ABC portable fire extinguisher located in the dining hallway was blocked by a cart and a wheelchair. Also, the K-class portable fire extinguisher in the kitchen was blocked by a trash can. Based on interview at the time of observation, the Maintenance Director acknowledged the blocked fire extinguishers and removed the equipment. The finding was reviewed with the Administrator and the Maintenance Director during the exit	K 0355	**K 355 Portable Fire Extinguishers** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Items blocking fire extinguishers in kitchen and dining hall were immediately removed. 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; · All residents have the potential to be affected by the deficient practice. · Audit of all other fire extinguishers was completed to ensure that no others were blocked. No issues found.	01/03/2023

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	conference. 3.1-19(b)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · - Maintenance/designee will round daily to ensure all fire extinguishers remain unobstructed. · - All Staff in-service to be completed by 1/3/23 per ED on not obstructing fire extinguishers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified Portable Fire Extinguishers will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 1/3/23 **Paper compliance is requested.**	

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K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wires and pipes through 4 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke	K 0372	**K 372 Subdivision of Building Spaces – Smoke Barriers** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Three smoke barrier walls above drop ceiling and one attic area were repaired to meet requirements for smoke	01/03/2023

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	barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice affects all residents. Findings include: Based on observations with the Maintenance Director and the Administrator on 12/05/22 between 11:50 a.m. and a 12:05 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of the dining hallway smoke wall there was a 1½ inch unsealed hole around wires. b) Above the drop ceiling of the 100-hall smoke wall there was a ½ inch unsealed hole around wires. c) Above the drop ceiling of the 200-hall smoke wall there was a ½ inch unsealed hole around wires. d) In the attic of the 300-hall smoke wall there was an eight-inch unsealed hole around a sprinkler pipe. Based on interview at the time of observation, the Maintenance Director and Administrator agreed the aforementioned smoke walls contained unsealed penetrations and provided the measurements. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		penetrations. 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; · All residents have the potential to be affected by the deficient practice. · All smoke barrier walls, ceiling areas and attic were inspected for penetrations, no additional areas were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · The Maintenance Director or designee will conduct an audit to identify penetrations in the fire walls, ceilings and attic weekly for 4 weeks, then monthly for 3 months and quarterly thereafter until compliance is achieved. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified Smoke Barrier will be completed weekly x	

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			4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 1/3/23 Paper compliance is requested.	