

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825
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K 000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/26/15 and 01/27/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/24/15</p> <p>Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700</p> <p>Surveyors: Amy Kelley, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</p> <p>At this PSR survey, University Park Health and Rehabilitation Center 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 was determined to be of Type V (000) construction and was</p>	K 000		
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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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K 029 SS=D Bldg. 01	<p>fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 104 and had a census of 63 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a garage providing facility services including the storage of maintenance supplies that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/31/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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	<p>inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchens, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/24/15 at 2:39 p.m., the Maintenance Supervisor confirmed the corridor door entering the kitchen from the service hall caught on a raised area of the floor and remained in the open position.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>	K 029	<p>1) The door jam has been re-aligned and no longer catches on the floor</p> <p>2) All service doors inspected for proper closure, and if needed, repaired at the time</p> <p>3) Staff was in-serviced on notifying maintenance regarding equipment needing repair Maintenance director/designee will inspect service doors weekly for proper closure and needed repairs</p> <p>4) Inspections will be forwarded monthly to quality assurance committee for tracking and trending</p>	04/22/2015
K 062 SS=D Bldg. 01	<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>Based on observation and interview, the</p>	K 062	<p>1) Shambaugh & Sons, LP, Fire Protection and Service replaced</p>	04/22/2015

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K 066	<p>facility failed to replace the loaded sprinkler head in 2 of 15 south hall resident rooms. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 of 16 residents in the East hall.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Service Director on 03/24/15 at 1:58 p.m., there was paint on the sprinkler heads in resident rooms 300 and 312. This was acknowledged by the Environmental Service Director at the time of observation.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>sprinkler heads in rooms 300 and 312</p> <p>2) All facility sprinkler heads were inspected to ensure they were in proper working condition.</p> <p>3.) Quarterly through TELS process maintenance or designee will inspect sprinkler heads to ensure they are in proper working condition.</p> <p>4) Inspections will be forwarded to quality assurance committee for tracking and trending.</p>	

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted residents was maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect at least 20 residents who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observations and interview on 03/24/15 at 2:02 p.m., the Environmental Service Director acknowledged there were at least 30 cigarette butts on the</p>	K 066	<p>1. Thecigarette butts were picked up off the ground near resident smoking area.</p> <p>2. Facilitystaff will maintain the designated smoking area for cleanliness and propercigarette disposal.</p> <p>3. Maintenance Director/designee to inspectresident designated smoking 3 times weekly for 1 month, then weekly thereafterto ensure compliance.</p> <p>4. Inspections will be forwarded to monthlyQuality Assurance committee for tracking and trending.</p>	04/22/2015			

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K 130 SS=E Bldg. 01	<p>ground in the designated resident smoke area. Each area was provided with a "smoker ' s oasis" which is a metal container with a long neck used for cigarette butts.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p>	K 130	<p>I.</p> <p>1.) Attic fire barrier wall penetrations were sealed with fire caulk.</p> <p>2.) Maintenance Director to inspect building for any further penetrations, and repair, at that time</p> <p>3.) Maintenance Director/designee will inspect building after contractor's access ceiling or any other situations potentially creating fire barrier penetration.</p> <p>4.) Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending.</p> <p>II.</p> <p>1. Batteries for all 53 smoke detectors have been tested and</p>	04/22/2015

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	<p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/24/15 at 2:15 p.m., the attic fire barrier wall near resident room 300 had an unsealed penetration measuring one half inch around a bundle of data cables and another hole measuring three fourths inch. This was acknowledged by the Maintenance Supervisor at the time of observation.</p>		<p>ensured they are functioning.</p> <p>2. Maintenance director to inspect and document smoke detector function on all 53 facilities smoke detectors minimum twice annually.</p> <p>3. Twice annually, through TELS program smoke detectors will be tested and documented. Twice annually batteries will be changed out and documented. The documentation will be faxed into TELS program by maintenance director.</p> <p>4. Inspection/documentation of smoke detector function will be presented to quality assurance committee for tracking and trending.</p>	

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	<p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a battery testing and replacement program was provided to ensure 53 of 53 single station smoke alarms would operate. This deficient practice affects all 58 residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 03/24/15 at 2:33 p.m., the Administrator acknowledged the facility did not have documentation of a battery testing and replacement program for the fifty three single station smoke alarms installed in resident rooms.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

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K 144 SS=F Bldg. 01	<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 maintain a complete written record of monthly generator load testing for 1 of 1 complete month since annual survey. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Test Generator" with the</p>	K 144	<p>1.) Generator load test was completed</p> <p>2.) Maintenance director to complete generator load test monthly as required.</p> <p>3.) Maintenance supervisor will fax into TELSsystem monthly documentation necessary for generator load test.</p> <p>4.) Documentation will be forwarded monthly to quality assurance committee for tracking and trending.</p>	04/22/2015
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	<p>Administrator on 03/24/15 at 2:25 p.m., there was no documentation of a generator load test for the month of February 2015. Based on an interview with the Administrator at the time of record review, she stated the generator load test was completed by the previous Maintenance Supervisor but she was unable to provide the documentation to confirm.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				