

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
--	---	--	---

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
--	---

(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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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: 01/06/16</p> <p>Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700</p> <p>At this Life Safety Code 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 (111) construction and was 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 59 at</p>	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
------------------------	---	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
--	---	--	---

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
--	---

(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
K 0029 SS=E Bldg. 01	<p>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>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 ensure the door to 1 of 1 storage rooms with combustibles, measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect up to 15 residents in 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0029	<p>It is the intent of this facility to assure that storage rooms measuring over 50 square feet to size, with combustibles is provided with a self closing device</p> <p>The storage room identified during the survey had a self closing device installed on 1/8/2016 by FCL Shop, Fort Wayne. Invoice # 10853. This installation was supervised by facility maintenance All other storage rooms were checked for this alleged deficiency and no</p>	02/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2016
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		
(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	
	<p>facility with the Maintenance Supervisor on 01/06/16 at 12:35 p.m., the door to the office storage room lacked a self closing device. The room measured over 50 square feet in size and contained 19 boxes of paper stacked on the floor and 20 plus plastic binders filled with paper on shelves. Based on interview at the time of observation, this was confirmed by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>		<p>deficient practice was found. The Business Office was re-educated to the storage of combustible materials and Iron Mountain will continue to be utilized to store documents off site in a timely and safe manner. An audit of this alleged deficient practice will be completed each month as part of the Preventive Maintenance and Safety Program to assure compliance For the next 6 weeks or until substantial compliance is determined by ISDH, compliance audits for this alleged deficiency will be conducted weekly by the Maintenance Supervisor/designee to identify potential non compliance concerns. Results of these audits will be reviewed by the Executive Director /designee and submitted to the Quality Assurance Committee monthly for review and recommendations. Date of Completion: February 5, 2016</p>		
K 0046 SS=C Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures in the generator transfer switch/electrical room would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated</p>	K 0046	<p>It is the intent of this facility to assure that battery powered emergency lighting will illuminate as needed, and be capable of repeated automatic operation. An audit of other emergency lighting tested and all were capable of automatic lighting and illuminated properly</p>	02/05/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
--	---	--	---

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
--	---

(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
K 0050 SS=F Bldg. 01	<p>automatic operation. This deficient practice could affect all residents if repairs are need on the transfer switch or other generator electrical equipment during a power outage.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Maintenance Supervisor on 01/06/16 at 11:55 a.m., the battery operated emergency light located in main electrical room which housed the generator transfer switch failed to illuminate when tested. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <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</p>		<p>The light identified during the survey process battery was replaced and tested. It then operated properly. Battery ticket # 001-343153</p> <p>An audit of this alleged deficient practice will be completed each month as part of the Preventive Maintenance and Safety Program to assure compliance</p> <p>For the next 6 weeks or until substantial compliance is determined by ISDH, compliance audits for this alleged deficiency will be conducted weekly by the Maintenance Supervisor/designee to identify potential non compliance concerns. Results of these audits will be reviewed by the Executive Director /designee and submitted to the Quality Assurance Committee monthly for review and recommendations. Date of Completion: February 5, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2016
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		
(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	
K 0066 SS=E Bldg. 01	<p>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 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the " Fire Drill Report" with the Maintenance Supervisor on 01/06/16 at 10:00 a.m., there was no record of a second shift fire drill for the first quarter of 2015. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 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,</p>	K 0050	<p>It is the intent of this facility to assure that fire drills are conducted monthly rotating shifts and days of week. An audit of fire drills since the hire of the present Maintenance Director revealed no other incidents of missed drills. Fire Drills are a part of the TELS tracking and preventative maintenance program and are to be completed monthly. These drills are held at varying shifts and days of the week each quarter. An audit of this alleged deficient practice will be completed each month as part of the Preventive Maintenance and Safety Program to assure compliance by the Executive Director or designee. For the next 6 weeks or until substantial compliance is determined by ISDH, compliance audits for this alleged deficiency will be conducted monthly by the Executive Director/designee to identify potential non compliance concerns. Results of these audits will be reviewed by the Executive Director /designee and submitted to the Quality Assurance Committee monthly for review and recommendations. Date of Completion: February 5, 2016</p>	02/05/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
--	---	--	---

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
--	---

(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
	<p>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>1. Based on observation and interview, the facility failed to ensure the proper disposal of cigarette butts in 1 of 2 smoking areas. The smoking areas were provided with metal containers with self-closing cover devices into which ashtrays can be emptied and were readily available. This deficient practice could affect at least 10 residents using the smoking area.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 01/06/16 at 12:17 p.m. in the resident designated smoking area; cigarettes butts and combustible trash were found in the metal container with a self-closing lid</p>	K 0066	It is the intent of this facility to assure the safety of Residents during social smoking activity with the proper and safe disposal of cigarette butts following the activity The designated smoking area was audited and any cigarette butts found not to be disposed of properly were The area was cleaned and all combustible trash was removed Facility staff will maintain the designated smoking area for cleanliness and proper cigarette butt disposal for safety of all Residents who smoke were re-educated as well as staff who monitor the smoke breaks related to the smoking policies, safe disposal of cigarette butts, and observance for any combustible materials in the area An audit of this alleged deficient practice will	02/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2016
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		
(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	
	<p>provided to empty ashtrays and the disposal of cigarette butts. Based on an interview at the time of observation, the Maintenance Supervisor acknowledged the can contained a mixture of combustible trash and cigarette butts.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted was maintained. This deficient practice could affect at least 10 residents using the smoking area.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 01/06/16 at 12:17 p.m., the resident designated smoking area was provided with a long neck approved container used for cigarette butt disposal, but there were at least 20 cigarette butts observed on the ground in the smoking area. Also, there were at least 40 cigarette butts put out in a planter. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>be completed each month as part of the Preventive Maintenance and Safety Program to assure compliance by the Maintenance Director or designee For the next 6 weeks or until substantial compliance is determined by ISDH, compliance audits for this alleged deficiency will be conducted weekly by the Maintenance Director/designee to identify potential non compliance concerns. Results of these audits will be reviewed by the Executive Director /designee and submitted to the Quality Assurance Committee monthly for review and recommendations. Date of Completion: February 5, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2016	
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			
(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			
K 0147 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient care area but could affect facility staff in the medical records and maintenance office.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Supervisor on 01/06/16 between 12:00 p.m. and 12:45 p.m., a coffee pot was plugged into an extension cord in the medical records office and a refrigerator was plugged into an extension cord power strip which was plug into another power strip in the maintenance office. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the power strips in the</p>	K 0147	<p>It is the intent of the facility to assure that flexible cords and cables shall not be used as a substitute for fixed wiring. All areas of the facility were inspected for any further non compliance concerns. None were noted</p> <p>Staff were educated to be aware of this concern while providing care, during Angel Rounds and in Managers Offices. Any non-compliance concerns are to be removed immediately and the Director of maintenance notified. An audit of this alleged deficient practice will be completed each month as part of the Preventive Maintenance and Safety Program to assure compliance by the Maintenance Director or designee</p> <p>For the next 6 weeks or until substantial compliance is determined by ISDH, compliance audits for this alleged deficiency will be conducted monthly by the Maintenance Director/designee to identify potential non compliance concerns. Results of these audits will be reviewed by the Executive Director /designee and submitted to the Quality Assurance Committee monthly for review</p>	02/05/2016			

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 01/06/2016
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		
(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	
	maintenance office and removed the extension cord in the medical records office. 3.1-19(b)		and recommendations. Date of Completion: February 5, 2016		