

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 09/09/2014
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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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K010000	<p>An investigation of Complaint Number IN001555014 was conducted by the Indiana State Department of Health.</p> <p>Complaint Number: IN00155014 Substantiated: Deficiencies related to the allegations are cited at K-45 and K-130.</p> <p>Date of Survey: 09/09/14</p> <p>Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>Census: 51</p> <p>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. in regard to the investigation of Complaint Number IN00155014.</p>	K010000		
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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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K010025 SS=E	<p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/12/14.</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 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation on 09/09/14 at</p>	K010025	K 025 The ceiling near the east hall attic access panel was repaired. The ceiling in the rest of the building was inspected and no gaps were found. When there is damaged dry wall on the ceiling it will be repaired or replaced immediately. This was added to the monthly TELS schedule. This will be monitored by the maintenance director monthly. The TELS schedule will be forwarded to the QA&A monthly for 3 months and then quarterly thereafter.	10/07/2014			

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K010045 SS=E	<p>7:50 p.m. with the Maintenance Supervisor, the ceiling near the east hall attic access panel was loose at the drywall seam leaving an eight inch gap. Based on an interview with the Maintenance Supervisor at the time of observation, he stated it looked like someone was in the attic and had mistakenly stepped on the drywall causing it to come loose and fall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>1. Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb would not leave the area in darkness at 3 of 5 exits. This deficient practice could affect any number of residents evacuated through the west exit, west lounge exit and the east exit in the event of an emergency.</p> <p>Finding include:</p> <p>Based on observations with the Executive Director and the Maintenance Supervisor on 09/09/14 from 8:20 p.m. to 8:35 p.m., the exterior exit lights at the west exit,</p>	K010045	K 045New bulbs were placed in the exit lights at the west exit, west lounge exit and the east exit. They were tested to assure they came on to provide continuous illumination when the power was transferred from normal to the emergency generator.All exit lights were checked to determine they provided continuous illumination and that they come on when the power is transferred from normal to the emergency generator.Checking the exit lights was added to the TELS schedule monthly.This will be monitored by the maintenance	10/07/2014

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	<p>west lounge exit and the east exit did not illuminate when all power was transferred to the emergency generator at 8:20 p.m. nor when the facility was returned to normal power at 8:35 p.m. The Maintenance Supervisor removed a bulb from one of the light fixtures and stated the light bulb was burned out and that was probably the problem with the remaining exit lights.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide continuous illumination for 1 of 5 exit discharges that could not be controlled by breaker switch. LSC Sections 7.8 requires continuous illumination during the time the conditions of occupancy require the means of egress be available for use. This deficient practice could affect any resident evacuated through the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/09/14 at 8:20 p.m., when all power was transferred from normal to the emergency generator the exterior exit lights were not illuminated until the Maintenance Supervisor</p>		<p>director monthly. The TELS schedule will be forwarded to the QA&A monthly for 3 months and then quarterly thereafter.</p>	

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K010130 SS=E	<p>manually flipped the breaker. This was confirmed by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 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:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one 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>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire</p>	K010130	K 130The hole in the east hall fire barrier wall in the attic was repaired and caulked with red fire resistant caulk. The rest of the fire barrier walls in the attic were checked for holes that were not repaired with fire resistant caulk. There are none. When the sprinkler system is worked on the fire barrier walls will be inspected to ensure there are no holes without firestop. This will be monitored by the maintenance director when work is performed on the sprinkler system. This will be reviewed by the QA&A monthly for 3 months then quarterly thereafter.	10/07/2014

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	<p>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 09/09/14 at 7:51 p.m., at the east hall fire barrier wall a hole was made in the block wall to install a new four inch sprinkler pipe in the attic. The annular space surrounding the sprinkler pipe lacked firestop. At the time of observation, the Maintenance Supervisor stated he was a new employee at the facility and was not aware of the penetration in the firewall.</p> <p>3.1-19(b)</p>			