

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 04/17/2014
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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>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: 04/17/14</p> <p>Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</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, in 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 55 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 which was not</p>	K010000		

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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K010029 SS=E	<p>sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 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 corridor door to 1 of 1 west 100 hall hazardous areas, such as a soiled linen room, was self closing and latched into the door frame. This deficient practice could affect 6 residents in the rear smoke compartment of the west 100 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Interim Administrator and the temporary Maintenance Director on 04/17/14 at 11:59 a.m., the west 100 hall soiled linen room corridor door did self close, but failed to latch into the door frame. This was acknowledged</p>	K010029	The door will be corrected to ensure that it is self-closing and latched into door frame and secure. The door will be checked weekly for two months and monthly thereafter.	05/17/2014			

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K010038 SS=E	<p>by the temporary Maintenance Director at the time of observation.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 exit doors were readily accessible at all times. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect all of the 13 residents in the Bed and Breakfast unit.</p> <p>Findings include:</p> <p>Based on observation with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 12:40 p.m., the exit door from the Bed and Breakfast unit dining room leading directly outside was equipped with a magnetic lock that released only upon activation of the fire alarm system. Based on an interview with the temporary Maintenance Director at the time of observation, there was no other way to open this exit door.</p>	K010038	Corrective action to have keypad installed to operate mag lock, per Life Safety Code.	05/17/2014			

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K010044 SS=E	<p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 west 100 hall fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition, NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 11 residents in both smoke compartments of the west 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the interim Administrator and the temporary Maintenance Director on 04/17/14 from 11:40 a.m. to 11:49 a.m., both of the west 100 hall fire door sets failed to latch into the door frame when tested. This was acknowledged by the temporary Maintenance Director at the time of observations, who confirmed these were fire doors.</p>	K010044	Doors have been adjusted and latch so positive latching is achieved on each door operation. Doors will be inspected weekly for two months and monthly thereafter.	05/17/2014
K010046 SS=D	<p>3.1-19(b) 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>			

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K010048 SS=F	<p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1\bd hour duration was tested monthly in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 12:03 p.m., a battery operated emergency light was observed in the west 100 hall water heater room. Based on an interview with the temporary Maintenance Director during record review at 2:20 p.m., he could only provide documentation of a monthly function test for August of 2013.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p>	K010046	Battery Back Emergency lighting will be put into Tels system program and to be checked 30 seconds monthly and 90 minutes annually. Facility to test Emergency Lighting equipment.	05/17/2014
	<p>Based on record review and interview, the facility failed to provide a written plan which</p>	K010048	The fire disaster plan will be updated and updated annually to ensure requirements are met. Staff to be in-serviced on plan.	05/17/2014

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	<p>included all necessary information in 1 of 1 written fire plans. LSC 19.7.1.1 requires a copy of the plan shall be readily available at all times. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>In addition, NFPA 99, Health Facilities, Chapter 16, Nursing Home Requirements at 16-3.11 says nursing homes shall comply with the provisions of Chapter 11 for emergency preparedness as appropriate. NFPA 99, 11-4.2 requires the senior management provide the staff with plans necessary to respond to a disaster or an emergency. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 2:34 p.m., the "Disaster Manual" did not include the following information:</p> <ol style="list-style-type: none"> a. use of the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system, b. evacuation of a smoke compartment, c. proper response procedures for activation of a resident room battery operated smoke detector. <p>Based on an interview with the interim</p>			

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K010050 SS=F	<p>Administrator and the temporary Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b) 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 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 review of the "Fire Drill Report" with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 11:15 a.m., there was no record of a first shift fire drill for the first quarter of 2014. Based on an interview with the temporary Maintenance Director 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>	K010050	Facility to conduct Fire Drills on accordance to NFPA 101 and Life Safety Code Standard which includes quarterly fire drills on each shift. Put into Tels Schedule to ensure compliance.	05/17/2014

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of ASG An EMCOR Company fire alarm system inspection titled "Inspection and Testing" with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 1:52 p.m., the most recent fire alarm system inspection occurred on 03/16/12. Based on an interview with the temporary Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the</p>	K010052	Facility conducted a fire alarm test on 4-20-14 by Vendor. Facility to monitor and maintain this system in accordance to applicable requirements of NFPA 72.	05/17/2014

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	<p>facility failed to ensure 41 of 41 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer' calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p>			

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K010062 SS=C	<p>Based on interview with the interim Administrator and the temporary Maintenance Director during the record review process on 04/17/14 from 1:52 p.m. to 2:34 p.m., the facility was unable to provided documentation of a smoke detector sensitivity test for the 41 smoke detectors in the building.</p> <p>3.1-19(b) 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 facility failed to replace 1 of 12 painted sprinkler heads in the corridor of the Bed and Breakfast unit. 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 any of the 13 residents in the Bed and Breakfast unit.</p> <p>Findings include:</p> <p>Based on observation with the interim Administrator and the temporary Maintenance Director on 04/17/13 at 12:44 p.m., there was paint on the sprinkler head near the door entering the Bed and Breakfast</p>	K010062	Painted sprinkler was replaced on 4-24-14. Facility to ensure that it meets LSC 9.7.5.	05/17/2014

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K010074 SS=E	<p>dining room. This was acknowledged by the temporary Maintenance Director at the time of observation.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 1 of 1 therapy rooms were flame retardant. This deficient practice could affect 4 residents in the therapy room.</p> <p>Findings include:</p> <p>Based on observation with the interim Administrator and the temporary Maintenance Director on 04/17/14 at 1:20 p.m., the window curtains in therapy room lacked attached documentation confirming they were inherently flame retardant. Based</p>	K010074	Therapy curtains were removed on 5-5-14. If curtains are used they are to meet provisions of 10.3.1 and NFPA 13.	05/17/2014

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K010130 SS=F	<p>on interview with the temporary Maintenance Director at 2:20 p.m., there was no documentation regarding flame retardancy for these window curtains available for review.</p> <p>3.1-19(b) NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure 5 of 5 water heaters had a current inspection certificate to ensure the water heaters were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Interim Administrator and the temporary Maintenance Director on 04/17/14 from 12:10 p.m. to 1:20 p.m., all five water heaters had a Certificate of Inspection that expired in 2011. Based on interview with the temporary Maintenance Director at 2:18 p.m., he was unable to provide documentation to show the water heaters had current Certificates of Inspection.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 53 of</p>	K010130	<p>1. Facility had 5 of 5 water heaters inspected to ensure safe operating conditions on 2-18-13.</p> <p>2. Smoke detectors were tested on 3-19-14. Items 1 & 2 to be put in Tels schedule to ensure compliance.</p>	05/17/2014

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	<p>53 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice affects all 55 residents.</p> <p>Findings include:</p> <p>Based on observation with the interim Administrator and the temporary Maintenance Director on 04/17/14 during the tour from 11:40 a.m. to 1:20 p.m., each of the 53 resident rooms had a battery operated smoke detector. Based on an interview with the temporary Maintenance Director during the record review process at 2:34 p.m., he was unable to provide documentation to confirm the battery operated smoke detectors received a monthly function test and the batteries were replaced annually.</p> <p>3.1-19(b)</p>			