STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417648 and Complaint IN00419499. Complaint IN00417648- Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00419499- No deficiencies are found realted to this allegation. Survey date: October 12, 2023 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 4 Medicaid: 60 Other: 1 Total: 65 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 16, 2023	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Faith Mills, | RN-DON | 10/31/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure elopement prevention interventions were in place for 1 of 3 residents reviewed. Findings include: During an observation on 10/12/23 at 9:18 AM, the surveyor pulled on the facility entrance door causing an alarm to sound. Resident A came to the front door, entered a code, and pushed the door open. 2 employees voices were heard coming from offices near the front door, but no employee was present in the office area when the surveyor entered the building. Within a few minutes, the Business Office Manager (BOM) came to the receptionist area and greeted the surveyor. She did not inquire how the surveyor as able to enter the facility. Resident A's record was reviewed on 10/12/23 at 11:22 AM. Diagnoses included depression, unspecified, generalized anxiety disorder, and hypothyroidism. A review of Resident A's current admission Minimum Data Set (MDS), dated 8/24/23, indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident A was out of the building for an appointment and not available for interview at the time of the review.	F 0689	**F 689** Free of Accident Hazards/Supervision/Devices **1)** =”” span=””> Resident A has been discharged from the facility. On 10/12/2023 the facility entrance door code was changed. Staff were educated that the door code is not to be shared with visitors or residents. 2) How the facility identified other residents: All residents are at risk to be affected by the deficient practice. 3) Measures put into place/ System changes: A sign is posted on the facility entrance door indicating that only staff are permitted to enter the code and allow visitors and/or residents to exit or enter the facility. All residents are assessed upon admission and with significant changes in status for elopement risk. Any residents identified as an elopement risk have had plan of care reviewed and updated related to elopement risk by 10/31/23. The facility entrance door code will continue to be changed/updated on a routine basis and upon any	10/31/2023

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	In an interview on 10/12/23 at 10:17 AM, the Administrator in Training (AIT) indicated only staff should have access to the door code. In an interview on 10/12/23 at 10:55 AM, the Admissions Coordinator indicated staff maintains the door code and does not share it with residents or families. She indicated the door remains locked with controlled entry due to a history of visitors bringing illicit substances to residents with histories of addictions. She indicated the door code is changed on a frequent, routine basis and upon discovery of an unauthorized person having knowledge of the code to promote resident safety. In an interview on 10/12/23 at 11:17 AM, the AIT indicated she would not be able to ensure an alert and oriented resident would be able to discern who should be allowed entry, be safe to exit the building, or if they would maintain privacy of the door code. She indicated due to privacy standards; an alert and oriented resident would not know the elopement risk status of other residents. A current policy dated Administrative Elopements, undated, provided by the Regional Nurse Consultant on 10/12/23 at 11:44 AM did not address keeping the door code secure. This citation is related to complaint IN00417648. 3.1-45(a)(2)		discovery of an unauthorized person having knowledge of the code. All staff have been educated on or before 10/31/23 that only staff are permitted to know the entrance door code and that upon the need for a visitor or resident to enter or exit a staff member will be required to enter the code. The facility department heads will participate in routine observations of the entrance door to monitor that only staff are entering the code for entrance and exit from the facility. The facility has a doorbell outside the entrance door for visitors/residents to ring to alert staff of need for entrance during hours when there is not office staff at the desk to assist with the entrance/exit of visitors/residents. ="" span.="" all="" assessed="" upon="" admission="" with="" significant="" changes="" in="" status="" for="" elopement="" risk.="" any="" identified="" as="" an="" risk="" have="" had="" plan="" of="" care="" reviewed="" updated="" related="" by="" 10="" 31="" 23.<="" span="">="" span="">="" span="">**span="">** **="" span="">** ="" span="">**span="">** ="" span="">="" span.="" all="" assessed=""	

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			upon="" admission="" with="" significant="" changes="" in="" status="" for="" elopement="" risk.="" any="" identified="" as="" an="" risk="" have="" had="" plan="" of="" care="" reviewed="" updated="" related="" by="" 10="" 31="" 23.<="" span=""> ="" span="">4) The Executive Director or other designee will be responsible to complete the " F-689 " tool daily for five days, then 3x weekly for the next 6 weeks, then weekly for the next 5 months to monitor for ongoing compliance. Any issues identified will be corrected upon discovery and results of the audits will be logged on facility QAPI log and communicated during the facility monthly QA meeting for a minimum of 6 months or until 100% compliance is achieved for 3 consecutive months. The QA team will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" span="">	