STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155567	A. BUILDING -- B. WING	07/18/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/24 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 At this Emergency Preparedness survey, University Park Rehabilitation and Healthcare was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 104 and had a census of 64 at the time of this survey. Quality Review completed on 07/19/24	E 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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.	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brent Swan	Executive Director	08/03/2024

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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	155567	A. BUILDING -- B. WING	07/18/2024

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

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	at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Administrator and Maintenance Director on 07/18/24 at 11:15 a.m., the EPP provided did not address alternate means for communication. The policy did list the primary means as telephones, but the secondary means was listed as "OTHER." Based on an interview at the time of records review, the Administrator agreed the alternate means for communication was not listed in the EPP. This finding was reviewed with the Maintenance Director and Administrator during the exit conference.	E 0032	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. Emergency preparedness manuals were immediately updated to reflect three means of alternate communication. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	07/19/2024

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			practice does not recur? The Emergency Preparedness Plan was updated on 7/19/24 to include three alternate forms of communication. Previous copies marked “Other” have been removed and updated copies now include 1) Handheld radio 2) Cellular devices 3) Email. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The Maintenance Director verified all Emergency Prep binders have been updated to reflect updated information. Additionally, the QAPI committee will audit binders quarterly to ensure communication tree remains current.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/24 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 At this Life Safety Code survey, University Park Rehabilitation and Healthcare was found not in	K 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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	

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	155567	A. BUILDING 01 B. WING	07/18/2024

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	compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 64 at the time of this survey. 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. Quality Review completed on 07/19/24		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			

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	155567	A. BUILDING 01 B. WING	07/18/2024

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	Based on observations, records review, and interview, the facility failed to ensure 2 of 5 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through- Penetration Fire Stops, 2010. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the administrator on 07/18/24 between 11:30 a.m. and 12:30 p.m., above the ceiling tiles by the dining room and conference room smoke barrier walls were sealed with pink foam. Based on records review at 12:35 p.m., there was no documentation to show the foam meets ASTM 814. Based on interview at the time of observation, the Maintenance Director stated the fire rating of the foam is unknown. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference 3.1-19(b)	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All 40 residents within the two areas had the potential to be affected by the alleged deficient practice. The Maintenance Director immediately replaced previous foam with appropriately rated fire barrier sealant. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All smoke barrier walls were again inspected by the Maintenance Director on 7/19/24. Previously installed fire foam at the two sites was removed completely and new 3M Barrier Sealant CP 25WB+ was installed per manufacturer's recommendation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?**	07/19/2024

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			Smoke barrier walls throughout the facility have been fully inspected and compliant. Walls will be audited going forward and reported by the Maintenance Director quarterly as part of the QAPI committee.	