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	07/06/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/06/23 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 07/10/23	E 0000	**The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

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

Goran Prentoski | Administrator | 07/26/2023

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	07/06/2023

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	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS			

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	155567	A. BUILDING -- B. WING	07/06/2023

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	Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,			

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	including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 07/06/23 at 10:25 a.m., the generator lacked monthly load testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	**E041 Hospital CAH and LTC Emergency Power** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Generator testing has been kept current and proper oversight has been put into place to ensure compliance is in place for monthly load testing.**	07/27/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			4)How the corrective action will be monitored: The Maintenance Director/designee will present Generator testing logs monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of Compliance: 27 July 2023**	
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: 07/06/23 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 At this Life Safety Code survey, University Park Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in	K 0000	**The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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***	

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	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 07/10/23		***and/or executed solely because it is required by the provisions of federal and state law.***	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 55 of 55 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and	K 0300	**K300 Protection- Other** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility's credible allegation of compliance.*** ***Preparation and/or execution of***	07/26/2023

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	Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director and Administrator on 07/06/23 at 10:58 a.m., the inspection, testing and maintenance (ITM) for the resident room battery-operated smoke alarms were marked as "complete" in the TELS computer system but there was not an itemized list for the ITM results for the battery-operated smoke alarms in each room. Based on interview at the time of review, the Maintenance Director stated the checks are marked done monthly in the TELS system but does the system does not itemize or show the inspection, testing and maintenance results for each smoke alarm. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Battery operated smoke detector tracking log has been generated and will be completed weekly by Maintenance Director/designee.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present the Battery-Operated Smoke Detector Logs monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality**	

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			Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of Compliance: 27 July 2023**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 rooms on the 100-hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 20 residents in the 100-hall. Findings include: Based on observation with Maintenance Director and the Administrator on 07/06/23 at 11:23 a.m., room 103 contained over 20 boxes of nursing supplies and was greater than 50 square feet making this a hazardous area. The room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Administrator agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	**K321 Hazardous Areas - Enclosure** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Room 103 has been cleaned and combustible materials**	07/26/2023

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			have been removed and stored in appropriate locations. **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present a weekly audit of 5 rooms at random to ensure monthly compliance to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 27 July 2023**	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other			

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	transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel and remote annunciator with the Administrator and the Maintenance Director on 07/06/23 at 12:15 p.m., the time and date on the display of the fire alarm control panel indicated the time and date was 10:51 p.m. 05/08/00 when checked at 12:15 p.m. on 07/06/23. Based on interview at the time of observation, the Administrator and the Maintenance Director agreed the fire alarm control panel time and date were incorrect. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0341	**K341 Fire Alarm System - Installation** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Vendor was contacted and date and time on fire panel and annunciators were corrected** **4)How the corrective action will**	07/26/2023

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			be monitored: **The Maintenance Director/designee will present a weekly audit of all fire information displayed monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 26 July 2023**	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in	K 0346	**K346 Fire Alarm System – Out of Service** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility's credible allegation of***	07/26/2023

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UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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	accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 07/06/23 at 12:50 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the state agency with a phone number but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **The facility's fire watch plan has been amended to include the IDOH Gateway link.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present an audit of the EPP monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance**	

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	155567	A. BUILDING 01 B. WING	07/06/2023

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			Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of Compliance: 27 July 2023**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall	K 0354	**K354 Sprinkler System – Out of Service** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or***	07/26/2023

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	follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 07/06/23 at 12:50 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview during the record review, the Administrator acknowledged the fire watch documentation provided stated to contact the state agency with a phone number but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **The facility's fire watch plan has been amended to include the IDOH Gateway link.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present an audit of the EPP monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make**	

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			recommendations to revise the plan of correction as indicated. **5)Date of Compliance: 26 July 2023**	
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. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 45 residents in four smoke compartments.	K 0372	**K372 Subdivision of Building Spaces – Smoke Barriers** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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***	07/27/2023

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	Findings include: Based on observations with the Maintenance Director on 07/06/23 between 12:55 p.m. and 1:15 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of the smoke wall by room 110 had a 3/4-inch unsealed gap around wires. b) Above the drop ceiling of the smoke wall by room 101 had a 3/4-inch unsealed gap around wires. c) Above the drop ceiling of the smoke wall by room 203 had a 2" x 2" unsealed cut out. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		***it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Penetrations to smoke barriers have been filled using an appropriately rated fire caulk.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present a weekly audit of smoke barrier penetrations monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 27 July 2023**	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets by the 200-hall mop sink were protected according to LSC 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 20 residents in the 200-hall. Findings include: Based on observations with the Maintenance Director and Administrator on 07/06/23 at 11:59 a.m., by the 200-hall mop sink, a GFCI receptacle was not provided with a faceplate. Based on interview at the time of observation, the Maintenance Director agreed the outlet was not covered with a faceplate. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**K511 Utilities-Gas and Electric** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into**	07/27/2023

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			place/System changes A faceplate has been added to the GFCI receptacle. 4)How the corrective action will be monitored: The Maintenance Director/designee will present a weekly audit of 10 receptacles monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of Compliance: 27 July 2023	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly,			

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	exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 07/06/23 at 10:25 a.m., no documentation for the months of October 2022 and May of 2023 were available for	K 0918	**K918 Electrical Systems-Essential Electrical Systems** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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***	07/26/2023

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	review to show the generator set in service was exercised under load at least once monthly, for a minimum of 30 minutes. Based on an interview at the time of records review, the Maintenance Director and Administrator stated the monthly load tests for October and May were not documented. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Generator testing has been kept current and proper oversight has been put into place to ensure compliance with the 30-minute load test.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present the weekly and monthly Emergency Power Generator Logs, as well as weekly audits, monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. **5)Date of Compliance: 26 July 2023**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the			

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	supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	#1.) Based on observation and interview, the facility failed to ensure 18 of 18 full and empty oxygen (O2) cylinders were separated and marked to avoid confusion. This deficient practice could affect up to 25 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and the Administrator on 07/06/23 at 11:30 a.m., the O2 storage room contained full and empty O2 cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Administrator agreed the O2 cylinders were not marked as full and empty. #2.) Based on observation and interview, the facility failed to ensure 1 of 1 O2 room doors contained a precautionary sign readable from 5 feet on each door of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This deficient practice could affect up to 25 residents in one smoke compartment. Findings include: Based on observations with the Maintenance	K 0923	**K923 Gas Equipment – Cylinder and Container Storage** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into**	07/27/2023

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	Director and the Administrator on 07/06/23 at 11:30 a.m., the O2 storage room contained O2 cylinders and liquid O2 and the door to the room did not contain a precautionary sign readable from 5 feet. Based on interview at the time of observation, the Administrator agreed the O2 storage door did not have a posted precautionary sign. The findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**place/System changes Individual areas have been created to separate full O2 cylinders from empty O2 cylinders. Proper signage for oxidizing gases and a no smoking warning has been put into place.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present a weekly audit of O2 room storage and signage monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 27 July 2023**	
K 0927 SS=B Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen (O2) storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 07/06/23 at 11:30 a.m., the O2 transfilling room contained liquid O2 tanks. The door to the room was not provided with sign that indicates when transfilling of O2 is occurring. Based on interview at the time of observation, the Administrator agreed there was not a sign that indicates when transfilling of O2 is occurring on or by the door. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0927	**K927 Gas Equipment – Transfilling Cylinders** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility'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.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.** **3)Measures put into place/System changes** **Appropriate signage has been**	07/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 01 B. WING	07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			placed on the O2 room door that indicates when transfilling is in progress. **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present a weekly audit of O2 room signage monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 27 July 2023**	