Goran Prentoski

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

07/26/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/06/2023	
	PROVIDER OR SUPPLIE SITY PARK REHAE	R BILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 07/0 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency University Park Refound in substantia Preparedness Required Medicaid Participa CFR 483.73. The finad a census of 64	6/23 00459 155567	E 0000	The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becatif is required by the provision of federal and state law.	of n of not f or the ed use
E 0041 SS=C Bldg	§482.15(e) Condi (e) Emergency ar The hospital mus standby power sy emergency plan s this section and ir procedures plan s (i) and (ii) of this s §483.73(e), §485 (e) Emergency ar The [LTC facility a implement emerg systems based or	d LTC Emergency Power tion for Participation: and standby power systems. It implement emergency and estems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1) section.			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GGJV21 Facility ID: 000459 If continuation sheet Page 1 of 26

Administrator

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BUILDING B. WING	onstruction 	COMPLETED 07/06/2023
	PROVIDER OR SUPPLIER SITY PARK REHAB	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	Emergency generator must be the location requirements and TIA 12-4, and Structure or building the location, testing requirements foun Facilities Code, NICode. 482.15(e)(2), §483 Emergency generator the lospital, CAI implement the eminspection, testing requirements foun Facilities Code, NICode. 482.15(e)(3), §483 Emergency generator the lospital, CAI implement the eminspection, testing requirements foun Facilities Code, NICode. 482.15(e)(3), §483 Emergency generator to power end LTC facilities source to power endared a plan for hopower systems opemergency, unless \$483.73(g), and Can the standards incomplete the properties of the power systems opemergency and LTC facilities source to power endared a plan for hopower systems opemergency, unless \$483.73(g), and Can the standards incomplete the properties of the	e located in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. Hand LTC facility] must ergency power system, and [maintenance] d in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency erational during the sit evacuates. \$482.15(h), LTC at AHs §485.625(g):] orporated by reference in proved for incorporation by birector of the Office of the in accordance with 5 U.S.C. part 51. You may obtain the sources listed below.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet

Page 2 of 26

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	î ´	JILDING	NSTRUCTION	(X3) DATE COMPI 07/06	LETED
	PROVIDER OR SUPPLIER	R BILITATION AND HEALTHCARE		1400 ME	DDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E ACTION SHOULD BE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	MATE	DATE
PREFIX	REGULATORY OF Information Resort Boulevard, Baltim Archives and Rec (NARA). For information this material at NA go to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the charannounce the charannounce the charannounce the charannounce (i) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issu (ii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014.	acy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION urce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a Federal Register to anges. Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION DATE
	edition, issued Au	gust 11, 2011.					
	(viii) TIA 12-1 to N 11, 2011.	NFPA 101, issued August					
	(ix) TIA 12-2 to NI 30, 2012.	FPA 101, issued October					
	l '	FPA 101, issued October					
	(xi) TIA 12-4 to NI 22, 2013.	FPA 101, issued October					
	l ' '	Standard for Emergency and ystems, 2010 edition,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 3 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

		IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 07/06/2023	
		ROVIDER OR SUPPLIER	R BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825			
(X4) PREF	ΊX	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
		2009 Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice of Findings include: Based on records refand Maintenance Da.m., the generator required by LSC an interview at the tim Maintenance Direct missing some of the The findings were refailed to implement the second s		E 00	041	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 this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision 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 in place for monthly load testing.	of n of not f or he d use ns	07/27/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $GGJV21 \qquad {\tt Facility\ ID:} \quad 000459$

If continuation sheet

Page 4 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/06/2023
	ROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400	r address, city, state, zip cod MEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				4)How the corrective action be monitored: The Maintenance Director/designee will press Generator testing logs more to the QAPI Committee dur QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will reviewed in Quality Assura Meeting monthly for 6 monor until 100% compliance is achieved. The QA Committe will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5)Date of Compliance: 27 J 2023	ent inthly ing be nce ths see
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000	The facility requests paper compliance for this citation This plan of correction is the facility's credible allegation compliance.	he n of
	Rehabilitation and l	55567		Preparation and/or execution this plan of correction does constitute admission or agreement by the provider the truth of the facts allege conclusions set forth in the statement of deficiencies. plan of correction is prepared.	s not of ed or e The

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 5 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	·		COMPLETED
		155567	B. WING		07/06/2023
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400	T ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR F WAYNE, IN 46825	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIDED OF AN AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the National Fire Protect Life Safety Code (L Health Care Occupation of this one story facility Type V (111) constructed in the sprinklered. The fact with smoke detection to the corridors and detectors in the resist capacity of 104 and of this survey. All areas where the access were sprinkle providing facility see	the corridors, areas open battery operated smoke dent rooms. The facility has a had a census of 64 at the time		and/or executed solely beca it is required by the provisio of federal and state law.	I
	Quality Review con	npleted on 07/10/23			
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMAR Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NR should be included Based on record rev observation, the fact documentation for to of 55 of 55 battery or resident rooms was 4.6.12.3 states exist	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. view, interview, and ility failed to ensure the preventative maintenance operated smoke alarms in complete. NFPA 101 in ing life safety features obvious	K 0300	K300 Protection- Other The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation compliance.	I
	-	required by the Code, shall be 72, 29.10 Maintenance and		Preparation and/or execution	n of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 6 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155567	B. W	ING		07/06/2023	
				CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
		NU ITATION AND LIEALTHOADE			EDICAL PARK DR		
UNIVERS	DILY PARK REHAB	BILITATION AND HEALTHCARE		FORTV	VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Tests. Fire-warning	equipment shall be maintained			this plan of correction does	not	
	and tested in accord	lance with the manufacturer's			constitute admission or		
	published instructions and per the requirements				agreement by the provider o	f	
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,				the truth of the facts alleged		
	-	testing, and maintenance programs shall satisfy			conclusions set forth in the		
	-	this Code and conform to the			statement of deficiencies. To	he	
	-	eturer's published instructions.			plan of correction is prepare		
	This deficient practice could affect all residents,				and/or executed solely beca		
	staff, and visitors.	•			it is required by the provision		
	,				of federal and state law.		
	Findings include:				1)Immediate actions taken fo	or	
					those residents identified:		
	Based on records review with the Maintenance				No resident was found to be		
	Director and Administrator on 07/06/23 at 10:58				affected by the finding.		
		, testing and maintenance			2)How the facility identified		
	_	ent room battery-operated			other residents:		
		marked as "complete" in the			Visitors, staff, and residents		
		stem but there was not an			that reside in the community	,	
	itemized list for the				have the potential to be		
	battery-operated sm	noke alarms in each room.			affected by the alleged		
		at the time of review, the			deficient practice.		
		tor stated the checks are			3)Measures put into		
	marked done month	nly in the TELS system but			place/System changes		
		es not itemize or show the			Battery operated smoke		
	inspection, testing a	and maintenance results for			detector tracking log has bee	en	
	each smoke alarm.				generated and will be		
					completed weekly by		
	This finding was re	viewed with the Administrator			Maintenance		
	_	irector during the exit			Director/designee.		
	conference.	-			4)How the corrective action v	will	
					be monitored:		
	3.1-19(b)				The Maintenance		
	, ,				Director/designee will preser	nt	
					the Battery-Operated Smoke		
					Detector Logs monthly to the		
					QAPI Committee during QAP		
					Meetings to ensure completi		
					of any new necessary update		
					and compliance. The report		
					will be reviewed in Quality		
1	i e		1		,	i	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 7 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/06/2023
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of Compliance: 27 Jul 2023	ny he ed.
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of hat are deficient in			
	c. Repair, Mainten	er than 100 square feet) nance, and Paint Shops noms (exceeding 64			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21

Facility ID: 000459

If continuation sheet

Page 8 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155567	B. WI	NG		07/06/	/2023
NAME OF I	PROVIDER OR SUPPLIER	<u>. </u>			ADDRESS, CITY, STATE, ZIP COD	1	
UNIVER	SITY PARK REHAB	SILITATION AND HEALTHCARE			VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	e. Trash Collection						
	(exceeding 64 gal	· · ·					
		orage Rooms/Spaces					
	(over 50 square fe	•					
		classified as Severe					
	Hazard - see K322)		17.0		1/004 11		07/06/0000
		on and interview, the facility f 1 rooms on the 100-hall with	K 0	521	K321 Hazardous Areas -		07/26/2023
					Enclosure		
	_	mbustible storage and greater			The facility requests paper compliance for this citation.		
	than 50 square feet was protected as a hazardous area. This deficient practice could affect 20				This plan of correction is the	.	
	residents in the 100	•			facility's credible allegation		
	residents in the 100	Tidii.			compliance.	01	
	Findings include:				compnance.		
	8				Preparation and/or execution	n of	
	Based on observation	on with Maintenance Director			this plan of correction does		
		tor on 07/06/23 at 11:23 a.m.,			constitute admission or		
		l over 20 boxes of nursing			agreement by the provider o	f	
		eater than 50 square feet			the truth of the facts alleged		
	making this a hazar	dous area. The room was not			conclusions set forth in the		
	protected as a hazar	dous area because the			statement of deficiencies. T	he	
	corridor door to the	room was not self-closing or			plan of correction is prepare	d	
	_	Based on interview at the time			and/or executed solely beca	use	
		Administrator agreed the			it is required by the provisio	ns	
		ined large amount of			of federal and state law.		
		e, was larger than 50 square			1)Immediate actions taken for	r	
	l '	or door to the room was not			those residents identified:		
	self-closing.				No resident was found to be		
	The finding was	viewed with the Administrator			affected by the finding.		
	_	be Director during the exit			2)How the facility identified other residents:		
	conference.	o Director during the exit			Visitors, staff, and residents		
	conference.				that reside in the community		
	3.1-19(b)				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		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 9 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BUILDING B. WING	01	COMPLETED 07/06/2023
	ROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				have been removed and stor in appropriate locations. 4)How the corrective action of the 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 completi of any new necessary update and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise to plan of correction as indicated. 5)Date of Compliance: 27 Jul 2023	will on es for ny he ed.
K 0341 SS=C Bldg. 01	and components a accordance with N Code, and NFPA 7 Code to provide ef part of the building occupied, detection alarm control unit. detection is also in appliance circuit possible.	n - Installation n is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm fective warning of fire in any In areas not continuously n is installed at each fire In new occupancy, astalled at notification ower extenders, and n transmitting equipment.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet

Page 10 of 26

, ´		X2) MULTIPLE CONSTRUCTION X3) DATE SURV. A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING		01	07/06/2023	
		155567	B. W.	_		07/06/	۷023 ————————————————————————————————————
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	SITY DARK DEUAD	SILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825				
	SITT FARR REHAD	SELITATION AND HEALTHCARE		FORT	WATNE, IN 40023		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		s are monitored for	1	IAU			DATE
	integrity.	s are monitored for					
	18.3.4.1, 19.3.4.1,	, 9.6, 9.6.1.8					
		on and interview, the facility	K 0	341	K341 Fire Alarm System -		07/26/2023
	failed to ensure 1 of	f 1 fire alarm systems was			Installation		
	continuously in pro	per operating condition.			The facility requests paper		
		Fire Alarm and Signaling Code,			compliance for this citation.		
		on 14.2.1.2.2 states system			This plan of correction is the		
	defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff				facility's credible allegation	of	
					compliance.		
	and visitors.				Businessation and/out assessation		
	Findings include:				Preparation and/or execution this plan of correction does		
	Tindings include.				constitute admission or	1101	
	Based on observation	on of the fire alarm control			agreement by the provider o	f	
	panel and remote ar				the truth of the facts alleged		
	1 ^	he Maintenance Director on			conclusions set forth in the		
	07/06/23 at 12:15 p	.m., the time and date on the			statement of deficiencies. T	he	
	display of the fire a	larm control panel indicated			plan of correction is prepare	ed	
		as 10:51 p.m. 05/08/00 when			and/or executed solely beca	use	
	_	m. on 07/06/23. Based on			it is required by the provisio	ns	
		e of observation, the			of federal and state law.		
		he Maintenance Director			1)Immediate actions taken fo	or	
	were incorrect.	n control panel time and date			those residents identified: No resident was found to be		
	were mediteet.				affected by the finding.		
	The finding was rev	viewed with the Maintenance			2)How the facility identified		
	_	nistrator during the exit			other residents:		
	conference.				Visitors, staff, and residents		
					that reside in the community	,	
	3.1-19(b)				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	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 11 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	l í	ILDING	ONSTRUCTION 01	(X3) DATE COMPL 07/06/	ETED
	PROVIDER OR SUPPLIE SITY PARK REHAL	R BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0346 SS=C	NFPA 101	m - Out of Service		-	be monitored: The Maintenance Director/designee will prese a weekly audit of all fire information displayed montl to the QAPI Committee durin QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will reviewed in Quality Assuran Meeting monthly for 6 montl or until 100% compliance is achieved. The QA Committe will identify any trends or patterns and make recommendations to revise plan of correction as indicate 5)Date of Compliance: 26 Ju 2023	hly ng be ice hs e	
Bldg. 01	Fire Alarm - Out of Where required fit services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to 9.6.1.6 Based on record refailed to provide a for the protection of procedures to be for alarm system has to	of Service re alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall he building shall be approved fire watch shall be arties left unprotected by the e fire alarm system has	K 0:	346	K346 Fire Alarm System – O of Service The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation	e	07/26/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21

Facility ID: 000459

If continuation sheet

Page 12 of 26

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	· /	JILDING	01	COMPL	
		155567	B. WI	NG		07/06/	/2023
				CTDEET A	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
	SITY PARK REHAE	BILITATION AND HEALTHCARE			VAYNE, IN 46825		
	DITTI ANN NEITHE	SILITATION AND HEALTHOAKE	,	IORIV	TVATINE, IIN 40023		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		SC, Section 9.6.1.6. This			compliance.		
	deficient practice a	ffects all occupants.				_	
	E. 1 1 1				Preparation and/or execution		
	Findings include:				this plan of correction does	not	
	Dagad or ""	avian with the Maintenan			constitute admission or		
		eview with the Maintenance nistrator on 07/06/23 at 12:50			agreement by the provider of		
					the truth of the facts alleged		
	p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at				conclusions set forth in the statement of deficiencies.		
					plan of correction is prepare		
	-	h.in.gov as the primary method			and/or executed solely beca		
		y method when the IDOH			it is required by the provision		
		erational by completing the			of federal and state law.		
	Incident Reporting form and e-mailing it to				1)Immediate actions taken f	or	
		n.gov. Based on interview			those residents identified:		
	-	eview, the Administrator			No resident was found to be)	
	-	fire watch documentation			affected by the finding.		
	-	contact the state agency with a			2)How the facility identified		
	-	not via the IDOH Gateway link			other residents:		
	or at the e-mail add	-			Visitors, staff, and residents	•	
					that reside in the community		
		eviewed with the Administrator			have the potential to be		
	and Maintenance D	Director during the exit			affected by the alleged		
	conference.				deficient practice.		
					3)Measures put into		
	3.1-19(b)				place/System changes		
					The facility's fire watch plan	l	
					has been amended to includ	le	
					the IDOH Gateway link.		
					4)How the corrective action	will	
					be monitored:		
					The Maintenance		
					Director/designee will prese		
					an audit of the EPP monthly	το	
					the QAPI Committee during		
					QAPI Meetings to ensure		
					completion of any new		
					necessary updates and	ho	
					compliance. The report will		
			1		reviewed in Quality Assuran	ICE	I

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567 AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567 A. BUILDING 1 B. WING			COMPLETED 07/06/2023	
	ROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR NAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Meeting monthly for 6 month or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise t plan of correction as indicate 5)Date of Compliance: 27 Jul 2023	he ed.
K 0354 SS=C Bldg. 01	extent and duration been determined, are inspected and recommendations management or de and the fire depart having jurisdiction the sprinkler syste than 10 hours in a building or portion evacuated or an approvided until the sereturned to service 18.3.5.1, 19.3.5.1, Based on record reversaled to provide 1 of the event the automa placed out-of-service 24-hour period in acceptable 24.5. LSC 9.7.6 responsedures comply the Standard for the Maintenance of War Systems. NFPA 25.	Out of Service er system is impaired, the n of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, ment and other authorities have been notified. Where m is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0354	K354 Sprinkler System – Out 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 this plan of correction does constitute admission or	of n of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21

Facility ID: 000459

If continuation sheet

Page 14 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155567	B. WI	NG		07/06/2023
NAME OF T	ADOLUDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF P	PROVIDER OR SUPPLIER	t .		1400 M	EDICAL PARK DR	
UNIVERS	SITY PARK REHAB	SILITATION AND HEALTHCARE	_	FORT V	WAYNE, IN 46825	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	` /	(b) states a fire watch should			agreement by the provider o	
	_	ersonnel who continuously			the truth of the facts alleged	or
	patrol the affected area. Ready access to fire				conclusions set forth in the	
	extinguishers and the ability to promptly notify				statement of deficiencies. T	he
	the fire department are important items to				plan of correction is prepare	ed
	consider. During the patrol of the area, the person				and/or executed solely beca	use
	should not only be looking for fire, but making				it is required by the provisio	ns
	sure that the other fire protection features of the				of federal and state law.	
		ress routes and alarm systems			1)Immediate actions taken fo	or
		nctioning properly. This			those residents identified:	
	deficient practice co	ould affect all occupants in the			No resident was found to be	
	facility.				affected by the finding.	
					2)How the facility identified	
	Findings include:				other residents:	
					Visitors, staff, and residents	
	Based on records re	view with the Maintenance			that reside in the community	,
	Director and Admir	nistrator on 07/06/23 at 12:50			have the potential to be	
	p.m., the fire watch	plan failed to include			affected by the alleged	
	contacting the India	na Department of Health via			deficient practice.	
	the IDOH Gateway	link at			3)Measures put into	
	https://gateway.isdl	n.in.gov as the primary method			place/System changes	
	or by the secondary	method when the IDOH			The facility's fire watch plan	
	Gateway is nonoper	rational by completing the			has been amended to includ	e
	Incident Reporting	form and e-mailing it to			the IDOH Gateway link.	
	incidents@health.ir	n.gov. Based on interview			4)How the corrective action	will
	during the record re	view, the Administrator			be monitored:	
	acknowledged the f	ire watch documentation			The Maintenance	
	provided stated to c	ontact the state agency with a			Director/designee will preser	nt
	phone number but r	not via the IDOH Gateway link			an audit of the EPP monthly	to
	or at the e-mail add	ress listed above.			the QAPI Committee during	
					QAPI Meetings to ensure	
	This finding was re	viewed with the Administrator			completion of any new	
	and Maintenance D	irector during the exit			necessary updates and	
	conference.				compliance. The report will b	pe
					reviewed in Quality Assuran	
	3.1-19(b)				Meeting monthly for 6 month	
					or until 100% compliance is	
					achieved. The QA Committee	e
					will identify any trends or	
					patterns and make	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 15 of 26

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING D1 B. WING			(X3) DATE SURVEY COMPLETED 07/06/2023	
	ROVIDER OR SUPPLIER SITY PARK REHAB	ILITATION AND HEALTHCARE	1400 N	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				recommendations to revise t	· -	
				5)Date of Compliance: 26 Jul 2023	ly	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers where an is installed for smotto the smoke barrier systems where an is installed for smotto the smoke barrier system in REMAR Based on observation failed to ensure the passage of wire and smoke barrier walls smoke resistance of Section 8.5.6.2 require cable trays, conduits and similar items to mechanical, plumbin systems that pass the floor/ceiling assembly barrier, or through the roof/ceiling of a smooth protected by a system systems that postrier, or through the roof/ceiling of a smooth protected by a system systems that postrier, or through the roof/ceiling of a smooth protected by a system stricting the move	all be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an ele dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.) hanical smoke control eKS. In and interview, the facility penetrations caused by the for conduit through 3 of 5 were protected to maintain the each smoke barrier. LSC cires penetrations for cables, so, pipes, tubes, vents, wires, accommodate electrical, and, and communications rough a wall, floor, or only constructed as a smoke the ceiling membrane of the oke barrier assembly, shall be an or material capable of ment of smoke. This deficient to taff and at least 45 residents	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 compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepared and/or executed solely became to the statement of deficiencies.	e of n of not f or he	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet

Page 16 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155567	B. W	NG		07/06/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			EDICAL PARK DR		
UNIVERS	SITY PARK REHAR	SILITATION AND HEALTHCARE			VAYNE, IN 46825		
			ı				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	F2' 1' ' 1 1				it is required by the provisio	ns	
	Findings include:				of federal and state law.		
	D 1 1	State No. 1			1)Immediate actions taken fo	or	
		ons with the Maintenance			those residents identified:		
		3 between 12:55 p.m. and 1:15			No resident was found to be		
	p.m., the following unsealed penetrations were discovered:				affected by the finding.		
		eiling of the smoke wall by			2)How the facility identified other residents:		
		-					
	room 110 had a 3/4-inch unsealed gap around wires.				Visitors, staff, and residents that reside in the community		
	b) Above the drop ceiling of the smoke wall by				have the potential to be		
	room 101 had a 3/4-inch unsealed gap around				affected by the alleged		
	wires.				deficient practice.		
		eiling of the smoke wall by			3)Measures put into		
		x 2" unsealed cut out.			place/System changes		
		at the time of observation, the			Penetrations to smoke barrie	ers	
		for agreed the aforementioned			have been filled using an		
		ned unsealed penetrations.			appropriately rated fire caulk	. .	
		•			4)How the corrective action v		
	This finding was re	viewed with the Maintenance			be monitored:		
	Director and Admir	nistrator during the exit			The Maintenance		
	conference.				Director/designee will preser	nt	
					a weekly audit of smoke		
	3.1-19(b)				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 Assuran		
					Meeting monthly for 6 month	s	
					or until 100% compliance is		
					achieved. The QA Committee	•	
					will identify any trends or		
					patterns and make recommendations to revise t	ho	
					plan of correction as indicate	a.	
					5)Date of Compliance: 27 Jul	v	
					2023	,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $GGJV21 \qquad {\tt Facility\ ID:} \quad 000459$

If continuation sheet Page 17 of 26

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/06/2023	
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of 200-hall mop sink wi LSC 19.5.1. NFPA Receptacle Faceplate receptacle faceplate completely cover the mounting surface. The affect 20 residents in Findings include: Based on observation Director and Admir a.m., by the 200-hall was not provided wi interview at the time Maintenance Direct covered with a face The finding was revenue.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 on and interview, the facility F1 electrical outlets by the vere protected according to 70, 2011 Edition, Article 406.6, tes (Cover Plates), requires s shall be installed so as to e opening and seat against the This deficient practice could in the 200-hall. ons with the Maintenance distrator on 07/06/23 at 11:59 Ill mop sink, a GFCI receptacle ith a faceplate. Based on e of observation, the or agreed the outlet was not	K 0511	K511 Utilities-Gas and Electr The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely beca it is required by the provision 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	of n of not f or the ed use ns	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet

Page 18 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/06/2023
	PROVIDER OR SUPPLIE SITY PARK REHAE	R BILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				place/System changes A faceplate has been added the GFCI receptacle. 4)How the corrective action be monitored: The Maintenance Director/designee will prese a weekly audit of 10 receptacles monthly to the QAPI Committee during QAF Meetings to ensure complet of any new necessary updat and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise plan of correction as indicat 5)Date of Compliance: 27 Ju 2023	will nt Pl on es for ny the ed.
K 0918 SS=F Bldg. 01	Electrical System System Maintena The generator or source and associon of supplying servi 10-second criteric monthly test, a prannually confirm safety and critical and testing of the switches are performed.	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power stated equipment is capable ce within 10 seconds. If the on is not met during the ocess shall be provided to this capability for the life branches. Maintenance generator and transfer ormed in accordance with			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $GGJV21 \qquad {\tt Facility\ ID:} \quad 000459$

If continuation sheet Page 19 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155567	B. WI	NG _		07/06	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			EDICAL PARK DR		
UNIVERS	SITY PARK REHAR	BILITATION AND HEALTHCARE			WAYNE, IN 46825		
	Г		1		1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
		oad 30 minutes 12 times a					
	l ·	intervals, and exercised					
	I	onths 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						
		· · · · · · · · · · · · · · · · · · ·					1
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in						
	1	NFPA 111. Main and feeder					
	circuit breakers ar	re inspected annually, and a					
	program for period	dically exercising the					
	components is es	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	and readily availal	ble. EES electrical panels					
		arked, readily identifiable,					
	1	n normal power circuits.					
	· ·	ssibility of damage of the					
		source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,	17.0	010	KO40 Flandsian		07/26/2022
		view and interview, the facility complete written record of	K 0	918	K918 Electrical		07/26/2023
		load testing for 2 of the last 12			Systems-Essential Electrical		
	1	.4.4.1.1.4(a) of 2012 NFPA 99			Systems The facility requests paper		
	_	sting of the generator serving			compliance for this citation.		
		trical system to be in			This plan of correction is the	2	
		FPA 110, the Standard for			facility's credible allegation		
		ndby Powers Systems, Chapter			compliance.		
		actice could affect all			,		
	occupants.				Preparation and/or execution	n of	
					this plan of correction does		
	Findings include:				constitute admission or		
					agreement by the provider o	f	
		eview with the Maintenance			the truth of the facts alleged	or	
	Director and the Ad	lministrator on 07/06/23 at			conclusions set forth in the		
		mentation for the months of			statement of deficiencies. T	he	
	October 2022 and N	May of 2023 were available for			plan of correction is prepare	ed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 20 of 26

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ ′		NSTRUCTION	(X3) DATE SUI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLET	
		155567	B. WIN	NG		07/06/20	123
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE		1400 MI	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	review to show the	generator set in service was			and/or executed solely becal	use	
	exercised under load	d at least once monthly, for a			it is required by the provision	ns	
	minimum of 30 minutes. Based on an interview at the time of records review, the Maintenance Director and Administrator stated the monthly				of federal and state law.		
					1)Immediate actions taken fo	r	
					those residents identified:		
	load tests for Octob	er and May were not			No resident was found to be		
	documented.				affected by the finding.		
					2)How the facility identified		
	•	viewed with the Administrator			other residents:		
		irector during the exit			Visitors, staff, and residents		
	conference.				that reside in the community		
					have the potential to be		
	3.1-19(b)				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 v	will	
					be monitored:		
					The Maintenance		
					Director/designee will preser	nt	
					the weekly and monthly		
					Emergency Power Generator		
					Logs, as well as weekly audi		
					monthly to the QAPI Commit	ree	
					during QAPI Meetings to		
					ensure completion of any ne	w	
					necessary updates and		
					compliance. The report will b		
					reviewed in Quality Assurance		
					Meeting monthly for 6 month	3	
					or until 100% compliance is achieved. The QA Committee		
						;	
					will identify any trends or		
					patterns and make		
			1		recommendations to revise t	ne	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 21 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	01	COMPI	
THIE TENT	o. commenon	155567	B. W.		<u>51</u>	07/06	
		100007	D. W			07700	12020
NAME OF P	ROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP COD		
					EDICAL PARK DR		
UNIVERS	SITY PARK REHAE	BILITATION AND HEALTHCARE		FORT V	WAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					plan of correction as indica	ted.	
					5)Date of Compliance: 26 J	uly	
					2023		
IX 0000	NEDA 454						
K 0923	NFPA 101	Ordinator and Oracle					
SS=E		Cylinder and Container					
Bldg. 01	Storag	Cylinder and Container					
		Cylinder and Container					
	Storage	qual to 3,000 cubic feet					
		are designed, constructed,					
	-	accordance with 5.1.3.3.2					
	and 5.1.3.3.3.	accordance with 5.1.5.5.2					
	>300 but <3,000 d	cubic feet					
		are outdoors in an					
		n an enclosed interior					
		imited- combustible					
	· ·	door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
	from combustibles	s by 20 feet (5 feet if					
	sprinklered) or en	closed in a cabinet of					
	noncombustible c	onstruction having a					
	minimum 1/2 hr. f	ire protection rating.					
	Less than or equa	al to 300 cubic feet					
	In a single smoke	compartment, individual					
	cylinders available	e for immediate use in					
	-	s with an aggregate volume					
	· ·	ual to 300 cubic feet are not					
	•	red in an enclosure.					
	_	e handled with precautions					1
	as specified in 11						
		ign readable from 5 feet is					
	_	ate of a cylinder storage					1
		sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
	order of which the	ey are received from the	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21

Facility ID: 000459

If continuation sheet

Page 22 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	
		155567	B. W	ING		07/06	/2023
	PROVIDER OR SUPPLIER	SILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR NAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	supplier. Empty of from full cylinders cylinders with inte threshold pressure established. Emp avoid confusion. Care protected from 11.3.1, 11.3.2, 11.99) #1.) Based on obserfacility failed to ensoxygen (O2) cylind to avoid confusion. affect up to 25 residence compartment. Findings include: Based on observation Director and the Additional and the Additional affect with the Administrator agreemarked as full and the Administrator agreemarked as f	explaints are segregated. When facility employs gral pressure gauge, a econsidered empty is explaints stored in the open in weather. 3.3, 11.3.4, 11.6.5 (NFPA exation and interview, the sure 18 of 18 full and empty ers were separated and marked. This deficient practice could dents in one smoke.	K 0	TAG	CROSS-REFERENCED TO THE APPROPRIA	e of not or the ed use ons	
	Findings include: Based on observation	ons with the Maintenance			have the potential to be affected by the alleged deficient practice. 3)Measures put into		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet

Page 23 of 26

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/06/2023		
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	11:30 a.m., the O2 cylinders and liquid did not contain a pr 5 feet. Based on int observation, the Ad storage door did no sign.	Imministrator on 07/06/23 at storage room contained O2 If O2 and the door to the room ecautionary sign readable from erview at the time of Imministrator agreed the O2 It have a posted precautionary reviewed with the Maintenance Director at the			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 printo place. 4) How the corrective action of the monitored: The Maintenance Director/designee will present a weekly audit of O2 room storage and signage monthly 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 month or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of Compliance: 27 Jul 2023	will t to e ce es	
K 0927 SS=B Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Higl Oxygen Used for any gas from one	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GGJV21 Facility ID: 000459

If continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
155567		B. WING			07/06/2023			
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG			TAG		DEFICIENCY)		DATE	
TAG	to liquid oxygen cocontainers over 50 under 11.5.2.3.1 (liquid oxygen containers under 50 containers under 51 11.5.2.2 (NFPA 98 Based on observation failed to ensure 1 of storage/transfer roof indicating that trans 11.5.2.3.1(3) states, indicating that trans smoking is the imm This deficient practione smoke compart Findings include: Based on observation Director and Admir a.m., the O2 transfil tanks. The door to the with sign that indica occurring. Based on observation, the Adnot a sign that indica occurring on or by the finding was revenue.	ontainers or to portable of psi comply with conditions NFPA 99). Transfilling to ainers or to portable of psi comply with 1.5.2.3.2 (NFPA 99). of and interview, the facility of 1 liquid oxygen (O2) ms was provided with a sign ferring is occurring. NFPA 99 the area is posted with signs offilling is occurring and that ediate area is not permitted. ice could affect 20 residents in ment. ons with the Maintenance histrator on 07/06/23 at 11:30 lling room contained liquid O2 the room was not provided ates when transfilling of O2 is a interview at the time of ministrator agreed there was ates when transfilling of O2 is	K 09	927	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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely becaute it is required by the provision 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	e of n of not f or the ed use ns	07/27/2023	
					place/System changes	\n		
			l		Appropriate signage has bee	? []		

PRINTED: 07/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING <u>01</u> B. WING			COMPL	X3) DATE SURVEY COMPLETED 07/06/2023	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)			(X5) COMPLETION DATE	
					placed on the O2 room door that indicates when transfilling is in progress. 4)How the corrective action be monitored: The Maintenance Director/designee will prese a weekly audit of O2 room signage monthly to the QAP Committee during QAPI Meetings to ensure complet of any new necessary updat and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of Compliance: 27 Jul 2023	ing will nt l ion es for enny the ed.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GGJV21 Facility ID: 000459 If continuation sheet Page 26 of 26