PRINTED: 10/31/2022

	I OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRU- AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING — 155567 B. WING			ONSTRUCTION	(X3) DATE COMPI 10/04			
	PROVIDER OR SUPPLIER	LILITATION AND HEALTHCARE	•	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	SUMMARY (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)	E	(X5) COMPLETION DATE
E 0000 Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000			
E 0004 SS=C Bldg	University Park Rel found not in compli Preparedness Requi Medicaid Participat CFR 483.73. The fa had a census of 58 a Quality Review cord 403.748(a), 416.5 441.184(a), 485.124(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §466 §483.73(a), §485.68(a), §485.	200459 255567 289700 Preparedness survey, nabilitation and Healthcare was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 ncility has a capacity of 104 and at the time of this survey. Impleted on 10/11/22 4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The [facility] must comply with all applicable

Federal, State and local emergency preparedness requirements. The [facility]

> TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155567 B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022		
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR must develop esta comprehensive er program that mee section. The emer program must incl the following elem (a) Emergency Pla develop and main preparedness plan and updated at lea must do all of the * [For hospitals at §485.625(a):] Eme or CAH] must com Federal, State, an	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ments: an. The [facility] must tain an emergency that must be [reviewed], rest every 2 years. The plan following: §482.15 and CAHs at regency Plan. The [hospital holy with all applicable d local emergency	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	CAH] must develor comprehensive er program that mee section, utilizing a * [For LTC Facilitie Emergency Plan. develop and main preparedness plan and updated at lea * [For ESRD Facil Emergency Plan. develop and main preparedness plan and updated at lea	nergency preparedness ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency n that must be [evaluated], ast every 2 years.	E 0004		10/27/2022
	Preparedness Plan (EPP) at least annually in CFR 483.73(a). This deficient		This plan of correction constitutes the facilities	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER	R BILITATION AND HEALTHCARE	1400 N	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, 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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) SE COMPLETION DATE
	practice could affect Findings include: Based on records reand Environmental at 10:11 a.m., the E of 07/23/22 but it was not properly update information were fare Aperion Care and Conflicted with current Administrator and Director agreed the			credible allegation of compliance. Preparation and/or execution of this plan of correction of not constitute admission of agreement by the provider the truth of the facts allegate conclusions set forth in the statement of deficiencies. plan of correction is preparand/or executed solely because it is required by the provisions of federal and slaw. E004 Emergency Prepared Plan 1)Immediate actions taken those residents identified No resident was found to the affected by the finding. 2)How the facility identified other residents: Visitors, staff and resident reside at the community has the potential to be affected the alleged deficient praction. 3) Measures put into place System changes: Facility has reviewed and updated its Emergency Preparedness Plan. Communication of updates have been completed with	on loes or of ed or e The red the state that ave I by ice

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION C	COMPLETED 10/04/2022
	PROVIDER OR SUPPLIED	R BILITATION AND HEALTHCAF	1400	r address, city, state, zip cod MEDICAL PARK DR r WAYNE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				Staff, Residents, and necessa visitors.	ry
				4)How the corrective actions will be monitored:	
				The Maintenance Director/designee will present the Emergency Preparedness Plan monthly to the QAPI Committee during QAPI Meetings to ensure completio of any new necessary updates and compliance.	n
				The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identif any trends or patterns and make recommendations to revise the plan of correction a indicated.	y
				5) Date of compliance: 10/27/2	22
E 0031 SS=C Bldg	441.184(c)(2), 48	6.54(c)(2), 418.113(c)(2), 2.15(c)(2), 483.475(c)(2), .102(c)(2), 485.625(c)(2),			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING — B. WING STREET ADDRESS CITY STATE ZIR COD		CON	(X3) DATE SURVEY COMPLETED 10/04/2022				
	F PROVIDER OR SUPPLIE RSITY PARK REHAI	R BILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR FORT WAYNE, IN 46825				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUSC INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	III D DE	(X5) COMPLETION	
TAG	485.68(c)(2), 485.486.360(c)(2), 49 Emergency Offici §403.748(c)(2), § §441.184(c)(2), § §483.73(c)(2), §4 §485.68(c)(2), §4 §485.920(c)(2). [(c) The [facility] r an emergency prepared to the second secon	nation for the following: a tribal, regional, and local aredness staff. of assistance. es at §483.73(c):] (2) on for the following: a tribal, regional, and local aredness staff. ensing and Certification the State Long-Term Care as of assistance. §483.475(c):] (2) Contact e following: a tribal, regional, and local aredness staff.	TAG			DATE	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	l í	JILDING	ONSTRUCTION	(X3) DATE COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, 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)	ATE	(X5) COMPLETION DATE
	Agency. Based on record revised failed to ensure the communication plainformation for the tribal, regional, or listaff (ii) The State of Agency (iii) The Order Ombudsman (in accordance with deficient practice of Findings include: Based on record revised Director a 10/04/22 at 10:13 a preparedness communication This included The State, Tribal emergicant actinformation This included The State, Tribal emergicant actinformation Agency Long-Term Care Of assistance. Based record review, the Indirector stated the info but did not known information for Federal This finding was resulted.	nunication plan for Federal, ency preparedness staff was not available for review.	EO	031	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction do not 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 because it is required by the provisions of federal and stallaw. E031 Emergency Officials Contact Information 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 reside at the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/System changes:	es f or he d atte	10/27/2022

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 10/04/2022	
	ROVIDER OR SUPPLIER	LILITATION 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
					Facility has reviewed and updated its Emergency Offici Contact Information. 4)How the corrective actions will be monitored:		
					The Maintenance Director/designee will presen the Emergency Officials Contact Information monthly the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates are prese and in compliance.	to	
					The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identiany trends or patterns and make recommendations to revise the plan of correction a indicated.	i. ify	
					5) Date of compliance: 10/27/	22	
E 0037 SS=F Bldg	441.184(d)(1), 48 483.73(d)(1), 484	6.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1),					

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED B. WING 10/04/2022				
		155567	B. WING		10/04/2022		
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD			
UNIVERS	SITY PARK REHAR	BILITATION AND HEALTHCARE		IEDICAL PARK DR WAYNE, IN 46825			
	T			1	075		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	ì ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	486.360(d)(1), 49						
	EP Training Progr						
	§403.748(d)(1), §4	416.54(d)(1), §418.113(d)(1),					
		460.84(d)(1), §482.15(d)(1),					
		83.475(d)(1), §484.102(d)(1),					
		l85.625(d)(1), §485.727(d)					
	(1), §485.920(d)(1	I), §486.360(d)(1),					
	§491.12(d)(1).						
	*[For RNCHIs at 8	§403.748, ASCs at §416.54,					
		.15, ICF/IIDs at §483.475,					
	HHAs at §484.102	2, "Organizations" under					
	§485.727, OPOs a	at §486.360, RHC/FQHCs					
	at §491.12:]						
		ram. The [facility] must do					
	all of the following						
		n emergency preparedness					
	1 '	edures to all new and					
		viduals providing services nt, and volunteers,					
		eir expected roles.					
		ency preparedness training					
	at least every 2 ye	* · · · ·					
	1	mentation of all emergency					
	preparedness trai						
	1 ' '	staff knowledge of					
	emergency proced						
		cy preparedness policies					
	1	re significantly updated, the					
		duct training on the					
	updated policies a	ana proceaures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
	The hospice must	do all of the following:					
		n emergency preparedness					
	1	edures to all new and					
	1 - '	mployees, and individuals					
	I ' -	s under arrangement,					
	consistent with the						
i	(ii) Demonstrate s	iali knowledde ot	ı	1	i		

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155567	 JILDING	NSTRUCTION	COMPL 10/04	ETED
	F PROVIDER OR SUPPLIEF RSITY PARK REHAE	BILITATION AND HEALTHCARE	1400 ME	DDRESS, 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)	.ΤΕ	(X5) COMPLETION DATE
	at least every 2 ye (iv) Periodically re emergency prepa employees (includ with special emph the procedures ne and others. (v) Maintain docur preparedness trai (vi) If the emerger and procedures a hospice must con- updated policies a procedures. *[For PRTFs at §4 program. The PR' following: (i) Initial training ir policies and proce existing staff, indiv under arrangement consistent with the (ii) After initial train preparedness trai (iii) Demonstrate se emergency proced (iv) Maintain docur preparedness trai (v) If the emergen and procedures a PRTF must condu- policies and procedures and procedures and procedures and procedures and procedures and policies and procedures and policies and procedures and policies and procedures and in procedures and procedures an	gency preparedness training ears. Eview and rehearse its redness plan with hospice ding nonemployee staff), easis placed on carrying out ecessary to protect patients mentation of all emergency ning. Eview and rehearse its redness placed on carrying out ecessary to protect patients mentation of all emergency ning. Eview and emergency preparedness re significantly updated, the duct training on the and emergency preparedness edures to all new and eviduals providing services evices and volunteers, eir expected roles. Eview and emergency and emergency ning, every 2 years. Eview and rehearse its Eview and rehe				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTI A. BUILDI B. WING		NSTRUCTION	(X3) DATE : COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE	14	100 ME	DDRESS, CITY, STATE, ZIP COD EDICAL PARK DR /AYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	IC PRE: TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	existing staff, indireservices under an participants, and witheir expected role (ii) Provide emergat least every 2 ye (iii) Demonstrate semergency procesuricipants of whom to contact i (iv) Maintain docu (v) If the emergency procesures and procedures and procedures and procedures and procedures and procedures and procedures and procesuricipants of the following: (i) Initial training in policies and procesuring staff, indirection in the following: (ii) Initial training in policies and procesurity staff, indirection in the following of the following: (iii) Provide emergat least annually. (iii) Maintain docupreparedness trait (iv) Demonstrate semergency procesure for CORFs at § CORF must do all (i) Provide initial to preparedness polynew and existing services under an consistent with the	viduals providing on-site rangement, contractors, volunteers, consistent with ess. ency preparedness training ears. staff knowledge of dures, including informing at to do, where to go, and in case of an emergency. mentation of all training. hey preparedness policies re significantly updated, the fuct training on the updated edures. es at §483.73(d):] (1) The LTC facility must do all the emergency preparedness edures to all new and eviduals providing services int, and volunteers, eir expected role. ency preparedness training mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The lof the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155567	B. WING		10/04/2022
	PROVIDER OR SUPPLIEF	SILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	(iii) Maintain docu (iv) Demonstrate semergency procedures and signate equipment. (v) If the emerge and procedures and procedures and protection, and who for patients, person prevention, and coand disaster authors at least every 2 years and procedures are consistent with the (ii) Provide emergency procedures are consistent with the (iii) Provide emergency procedures are consistent with the (iii) Provide emergency procedures are consistent with the (iv) Demonstrate semergency procedures are consistent and proced	mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting ency preparedness policies re significantly updated, the uct training on the updated edures. 35.625(d):] (1) Training H must do all of the emergency preparedness edures, including prompt nguishing of fires, nere necessary, evacuation nnel, and guests, fire coperation with firefighting orities, to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. ency preparedness policies re significantly updated, the ct training on the updated			

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The CMHC must provide initial training in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER SITY PARK REHABILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR NAYNE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Environmental Services Director and the Administrator on 10/04/22 at 10:13 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Environmental Services Director stated the training documentation was not found. This finding was reviewed with the Administrator and Environmental Services Director during the	E 0037	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction doe not 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 because it is required by the provisions of federal and stallaw. E037 Emergency Preparedness Training Plan 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding.	f or he d

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	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BUILDING B. WING		COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER SITY PARK REHAB	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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR exit conference.	LSC IDENTIFYING INFORMATION	TAG	2)How the facility identified other residents: Visitors, staff and residents to reside at the community have the potential to be affected be the alleged deficient practice. 3) Measures put into place/System changes: Facility has reviewed and updated its Emergency Preparedness Plan. Staff members have been educated on the plan. Additional training will take course as necessary and on annual basis.	that e y
				4)How the corrective actions will be monitored: The Maintenance Director/designee will preser the Emergency Preparednes: Plan monthly to the QAPI Committee during QAPI Meetings to ensure completiof 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.	on es for eny

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022	
	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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
				5) Date of compliance: 10/27/22	
E 0039 SS=F Bldg	441.184(d)(2), 482.483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49. EP Testing Require \$416.54(d)(2), \$4.5460.84(d)(2), \$4.5460.84(d	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 848.102(d)(2), §485.68(d)(2), 8494.62(d)(2). 8494.62(d)(2). 6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at 2D Facilities at §494.62]: acility] must conduct the emergency plan slity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is induct a facility-based			

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 $PSWI21 \qquad {\tt Facility\ ID:} \quad 000459$

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155567	B. W	ING		10/04/	2022
NAME OF T	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER			1400 MI	EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	BILITATION AND HEALTHCARE		FORT V	VAYNE, IN 46825		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
	1 ' '	scale exercise that is					
	functional exercise	or individual, facility-based					
		•					
	(B) A mock disast	er drill, of ercise or workshop that is					
		and includes a group					
	discussion using a	.					
	_	emergency scenario, and a					
	set of problem sta	- ·					
	1	pared questions designed					
	to challenge an er	·					
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*[For Hospices at	/18 113/d)·1					
		spices that provide care in					
	_ , ,	e. The hospice must					
		s to test the emergency					
		ally. The hospice must do					
	the following:	any. The hospide much de					
		a full-scale exercise that is					
	community based						
		nunity based exercise is not					
		ict an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
	•	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	I	ctional exercise following the					
	onset of the emer						
	(ii) Conduct an ac	dditional exercise every 2					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/04/2022		
		ROVIDER OR SUPPLIER SITY PARK REHAB	BILITATION AND HEALTHCARE		1400 ME	DDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
	X4) ID REFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	TAG	years, opposite the functional exercises of this section is conclude, but is not (A) A second full-community-based functional exercises (B) A mock disass (C) A tabletop excled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepto challenge an error (3) Testing for hose care directly. The exercises to test the per year. The hose (i) Participate in a that is community-(A) When a community-(A) When a community-based functional exercises emergency exempt from engage full-scale community exempt from engage full-scale community-community-based functional exercises (B) A second full-community-based functional exercises (B) A mock disassi	ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required hity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or		TAG	DEFICIENCY)		DATE

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Event ID:

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PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 10/04/2022			
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
IAG	facilitator that inclusing a narrated, of emergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emother the hospice's emether th	cides a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an cospice's response to and nation of all drills, tabletop pergency events and revise ergency plan, as needed. 41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency exercise expands or nanual full-scale exercise expands or nanual individual, ational exercise; or dospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency exempt from engaging in ull-scale community based ty-based functional exercise at of the emergency event. In an [additional] annual at may include, but is not wing: scale exercise that is or individual, a ctional exercise; or ck disaster drill; or or exercise or workshop that or and includes a group	IAG	DEFICIENCE		DATE		
I	discussion, using	a namaleo,	i	I		1		

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	OF CORRECTION	IDENTIFICATION NUMBER 155567	 JILDING	NSTRUCTION	COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 MI	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, 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)	TE	(X5) COMPLETION DATE
	set of problem sta messages, or prep to challenge an er (iii) Analyze the and maintain docu tabletop exercises and revise the [fact needed.	pared questions designed nergency plan. The [facility's] response to sumentation of all drills, The and emergency events stillity's] emergency plan, as				
	conduct exercises plan at least annu- organization must (i) Participate in a that is community- (A) When a comm accessible, condu facility-based function (B) If the PACE exor man-made emeractivation of the elis exempt from en full-scale communifacility-based functionset of the emergence.	ACE organization must to test the emergency ally. The PACE do the following: n annual full-scale exercise based; or unity-based exercise is not ct an annual individual, tional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required ity based or individual, tional exercise following the gency event.				
	2 years opposite the functional exercise of this section is consumed to the functional exercise of this section is consumed to the functional exercise (A) A second full-community-based based functional exercise (B) A mock disast (C) A tabletop exercise by a facilitator discussion, using the functional exercise (B) and the functional exercise (B) an	scale exercise that is or individual, a facility exercise; or er drill; or ercise or workshop that is and includes a group				

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	ľ	JILDING	NSTRUCTION	(X3) DATE COMPI 10/04	LETED	
	PROVIDER OR SUPPLIED	R BILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR FORT 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	set of problem star messages, or pre to challenge an er (iii) Analyze the Finaintain docume exercises, and en the PACE's emerging to test the emergency properties of the	atements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop mergency events and revise gency plan, as needed. Ses at §483.73(d):] ity] must conduct exercises ency plan at least twice per mannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise e-based; or munity-based exercise is not act an annual individual, ectional exercise. Stility] facility experiences an man-made emergency that an of the emergency plan, the empt from engaging its next alle community-based or abased functional exercise ent of the emergency event. In other exercise is not limited to the exercise that is a for an individual, facility exercise; or exercise that is a for an individual, facility exercise; or exercise or workshop that is a includes a group a narrated, emergency scenario, and a externents, directed pared questions designed						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 10/04/2022			
		PROVIDER OR SUPPLIER SITY PARK REHAB	R BILITATION AND HEALTHCARE	1400 I	TADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR TWAYNE, IN 46825			
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION	
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	UPRIATE	DATE	
		(iii) Analyze the [l	LTC facility] facility's					•
		response to and n	naintain documentation of					
		all drills, tabletop	exercises, and emergency					
			e the [LTC facility] facility's					
		emergency plan, a	as needed.					
		*[For ICF/IIDs at §	§483.475(d)]:					
		(2) Testing. The IC	CF/IID must conduct					
		exercises to test t	he emergency plan at least					
			e ICF/IID must do the					
		following:						
			n annual full-scale exercise					
		that is community						
		` '	nunity-based exercise is not					
			ict an annual individual,					
		•	ctional exercise; or. experiences an actual					
		, ,	ade emergency that requires					
			mergency plan, the ICF/IID					
			gaging in its next required					
			nity-based or individual,					
			ctional exercise following the					
		onset of the emer	_					
			ditional annual exercise					
		` '	but is not limited to the					
		following:						
		(A) A second full-s	scale exercise that is					
		community-based						
			ctional exercise; or					
		(B) A mock disast						
		` '	ercise or workshop that is					
		-	and includes a group					
		discussion, using						
			emergency scenario, and a					
		set of problem sta						
		to challenge an er	pared questions designed					
			Thergency plan. CF/IID's response to and					
			ntation of all drills, tabletop					
			nergency events, and revise					
		CACICIOCO, AITU EIT	iorgonoy eventa, and revise	I			I	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTI A. BUILD B. WING		NSTRUCTION	(X3) DATE : COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER	R BILITATION AND HEALTHCARE	14	400 ME	DDRESS, CITY, STATE, ZIP COD EDICAL PARK DR /AYNE, IN 46825		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION rgency plan, as needed.	Tz	AG	DEFICIENCY)		DATE
	*[For HHAs at §48 (d)(2) Testing. The exercises to test to least annually. The following: (i) Participate in a community-based (A) When a cois not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-material o	e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is ; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual ade emergency that requires mergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the gency event. ditional exercise every 2 the year the full-scale or the under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is the or an individual, ctional exercise; or tisaster drill; or to exercise or workshop that toor and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					
	""" " " " " " " " " " " " " " " " " "	oney plain, as mosasan					

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	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BUILE B. WING	ING	CHON	COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE	1	TREET ADDRES 400 MEDICA ORT WAYNE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		EIX (EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	exercises to test the OPO must do the (i) Conduct a paper or workshop at least exercise is led by group discussion, relevant emergency problem statement prepared questions emergency plan. I actual natural or not require activation OPO is exempt from the emergency (ii) Analyze the OF maintain document exercises, and emotive the [RNHCI's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the the exercises to test the exercises the exerci	e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of tts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency that of the emergency plan, the om engaging in its next exercise following the onset event. PO's response to and otation of all tabletop mergency events, and revise OPO's] emergency plan, as 3.748]: e RNHCI must conduct the emergency plan. The	E 0039				10/27/2022
	Dasca on record lev	ion and mornion, the facility	Tr 0032				10/2//2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155567	B. WI	NG		10/04/	/2022
NAME OF T	ADOLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	t .		1400 M	EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	SILITATION AND HEALTHCARE	FORT WAYNE, IN 46825				
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tercises to test the emergency			This plan of correction		
	plan at least twice per year, including				constitutes the facilities		
		drills using the emergency			credible allegation of		
	-	C facility must do the			compliance.		
	following:	1011 1 1 1			Preparation and/or execution		
	• •	annual full-scale exercise that			of this plan of correction doe	es	
	is community-based				not constitute admission or		
		ity-based exercise is not			agreement by the provider of		
		an annual individual,			the truth of the facts alleged	or	
	facility-based funct				conclusions set forth in the		
		y experiences an actual natural			statement of deficiencies. The	_	
		gency that requires activation			plan of correction is prepare	d	
		lan, the LTC facility is exempt			and/or executed solely		
		ext required full-scale in a			because it is required by the		
	-	or individual, facility-based			provisions of federal and sta	te	
		l exercise for 1 year following			law.		
	the onset of the actu						
		itional exercise that may			E-039 SS-F: EP Testing REG		
	· ·	imited to the following:					
	a. A second full-sca						
		or an individual, facility-based			1. Immediate actions taken fo	or	
	functional exercise.				those residents identified:		
	b. A mock disaster				Administrator/Maintenance		
	-	se or workshop that is led by a			Director initiated a plan of		
		des a group discussion, using			correction to ensure		
		y-relevant emergency scenario,			compliance with the		
		n statements, directed			regulation.		
		red questions designed to					
	challenge an emerg				2. How the facility identified		
		CC facility's response to and			other residents:	•.	
		ation of all drills, tabletop			Current residents in the facil	ity	
		gency events, and revise the			have the potential to be		
	-	gency plan, as needed in CFR 483.73(d)(2). This			affected.		
		ould affect all occupants.			2 Magguras put into place!		
	deficient practice co	oute arrect air occupants.			3. Measures put into place/ System changes:		
	Findings include:				Gystein Ghanges.		
					The facility has completed a		
	Based on record rev	view with the Administrator			table top exercise per		
		ntal Services Director on			roquiromente		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER SITY PARK REHAE	BILITATION AND HEALTHCARE	1400 I	FADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR FWAYNE, IN 46825	
(X4) ID PREFIX TAG	(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	an actual emergenc documentation of a choice within the la review. Based on ir review, the Enviror	.m., there was documentation of y dated 12/14/21, but n additional annual exercise of lest year was not available for atterview at the time of records amental Services Director stated n of choice has not been he last 12 months.		Facility Emergency Operat Plan was reviewed with all management staff in regard E-039: EP Testing Requirements. 4. How the corrective actio will be monitored:	ds to
		viewed with the Administrator Services Director during the		The Emergency Preparedn drill participation will be reviewed at least quarterly. Audit findings will be presented to the QAPI Committee monthly x 6 months. The QAPI Committee will review findings and determ the need for further monitor and/or education per the Q process. Compliance will determined based on result audits. 5) Date of compliance: 10/27/22	nine oring A be
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency an The hospital must standby power sy emergency plan s this section and ir	I LTC Emergency Power tion for Participation: ad standby power systems. implement emergency and stems based on the et forth in paragraph (a) of a the policies and set forth in paragraphs (b)(1)			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. BUILDING B. WING			COMPLETED 10/04/2022		
	PROVIDER OR SUPPLIER SITY PARK REHAE	BILITATION AND HEALTHCARE		1400 MI	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
	The [LTC facility a implement emergy systems based or forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requirements and Tiangle (NFPA 101 Amendments Tiangle (NF	and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) eator location. The elocated in accordance with rements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 83.73(e)(2), §485.625(e)(2) eator inspection and testing. H and LTC facility] must regency power system ind and Imaintenance] ind in the Health Care FPA 110, and Life Safety 83.73(e)(3), §485.625(e)(3) eator fuel. [Hospitals, CAHs is that maintain an onsite fuel is the emergency generators must is wit will keep emergency iterational during the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. Bl	A. BUILDING B. WING		COMPLETED 10/04/2022		
	F PROVIDER OR SUPPLIEF RSITY PARK REHAE	SILITATION AND HEALTHCARE		1400 MI	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	this section are appreference by the EF Federal Register in 552(a) and 1 CFR the material from You may inspect a Information Resould Boulevard, Baltim Archives and Reco (NARA). For information this material at NA go to: http://www.archive_of_federal_regull of any changes in incorporated by redocument in the Federal and the Federal for the Common of the Change of the Common of	Protection Association, 1 k, p, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					

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Event ID:

PSWI21 Facility ID: 000459

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIEI SITY PARK REHAE	R BILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, 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)	(X5) COMPLETION DATE	
	22, 2013. (xi) TIA 12-4 to Ni 22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 2009. Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice of Findings include: Based on records refailed at 10:02 a.m., the g testing required by interview at the time Environmental Sergenerator was miss testing. The findings were refailed.	Environmental Services	E 0041	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction do not 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 because it is required by the provisions of federal and stallaw. E041 Hospital CAH and LTC Emergency Power 1) Immediate actions taken for those residents identified No resident was found to be affected by the finding.	es f or he d tte	

other residents:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETED B. WING 10/04/202			ETED		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	ILITATION AND HEALTHCARE			VAYNE, IN 46825		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	Visitors, staff and residents reside at the community have the potential to be affected be the alleged deficient practice. 3) Measures put into place/System changes: Facility has reviewed and completed monthly load test to meet the requirements. 4)How the corrective actions will be monitored: The Maintenance Director/designee will present the monthly load report to the QAPI Committe to ensure completion of any new load tests. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10/27	that e by a ing int e e in d ify as	DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION		SURVEY LETED -/2022	
	PROVIDER OR SUPPLIEF	BILITATION 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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
K 0000						
Bldg. 01			K 0000			
	sprinklered. The fact with smoke detection to the corridors and detectors in the resi	ruction and was fully bility has a fire alarm system on in the corridors, areas open battery operated smoke dent rooms. The facility has a had a census of 58 at the time				
	access were sprinkl providing facility so	residents have customary ered. The facility had a garage ervices including the storage of es that was not sprinklered.				
	Quality Review cor	npleted on 10/11/22				

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. BUILDING <u>01</u> B. WING			COMPL	(3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, 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)	TE	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be either or capable of auto manual intervention 18.2.8, 19.2.8 Based on observation failed to ensure the discharges was array and shall be either of capable of automatic intervention. This does not be a compared to the west hall. Findings include: Based on observation Services Director of means of egress out had two lights, but to out and had to be so come on. Based on observation, the Engareed the light bull lights would not control. This finding was reconstructed.	ans of Egress ans of egress, including exit aged in accordance with 7.8 continuously in operation matic operation without on. on and interview, the facility egress lighting for 1 of 5 exit aged in accordance with 7.8 continuously in operation or coperation without manual efficient practice could affect ons with the Environmental and 10/04/22 at 12:30 p.m., the exit saide the side west-hall exit the light bulbs were screwed rewed back in for the lights to interview at the time of wironmental Services Director as were screwed out and the	K 02	281	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction doe not 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 because it is required by the provisions of federal and stallaw. K281 Illumination of Means of Egress 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:	es f or ne d te	10/27/2022

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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 10/04/2022		
	PROVIDER OR SUPPLIED	BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, 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
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Visitors, staff and residents to reside at the community have the potential to be affected be the alleged deficient practice. 3) Measures put into place/System changes: To prevent the bulbs from coming unscrewed, an anti-tamper device has been installed. 4) How the corrective actions will be monitored: The Maintenance Director/designee will check the device daily during rounding and present finding during QAPI Meetings to ensure completion of any nenecessary 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 identiany trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10/27/	e y c c c c c c c c c c c c c c c c c c	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		155567	B. WI		<u> </u>	10/04/	
	PROVIDER OR SUPPLIE	R 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 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)	TE	(X5) COMPLETION DATE
K 0300 SS=C Bldg. 01	Section 18.3 and requirements that provided K-tags, information, along Safety Code or N should be included Based on record re observation, the fad documentation for of 55 of 55 battery resident rooms was 4.6.12.3 states exist to the public, if not maintained. NFPA Tests. Fire-warning and tested in accompublished instruction of Chapter 14. NFI testing, and mainted the requirements of equipment manufar This deficient pract staff, and visitors. Findings include: Based on records reservices Director and 11:15 a.m., no compreventative maint operated smoke ala Furthermore, the manufact requires weekly testings weekly testings weekly testings.	r RKS section any LSC	K 03	300	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction doe not constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. Tiplan of correction is prepare and/or executed solely because it is required by the provisions of federal and stallaw. K300 Protection-Other 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding.	es f or ne d	10/27/2022

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 10/04/2022
ROVIDER OR SUPPLIER	R BILITATION AND HEALTHCARE	1400 N	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825	•
SUMMARY (EACH DEFICIEN REGULATORY OF Environmental Servare marked done madoes not itemize or This finding was re		1400 N	MEDICAL PARK DR	nts that have ed by tice ee/ upport facility the ly audit.
			tool and note	e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/04/2022	
	ROVIDER OR SUPPLIE	R BILITATION AND HEALTHCARE	1400 N	ADDRESS, CITY, STATE, ZIP COD MEDICAL 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 APPROPRIDE TO THE APPROPRISE TO	DATE
				immediately. 4)How the corrective actions will be monitored: The Maintenance Director/designee will prese the to the audit during the QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed Quality Assurance Meeting monthly for 6 months or unt 100% compliance is achieve The QA Committee will iden any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10/27	in til ed. tify

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. BUILDING <u>01</u> COMP			(X3) DATE S COMPL 10/04/	ETED	
	PROVIDER OR SUPPLIER SITY PARK REHAB	BILITATION AND HEALTHCARE		1400 MI	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinus accordance 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	are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting or in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of that are deficient in					
	a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gall f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 Based on observation failed to ensure 1 of amounts of combust	lons) orage Rooms/Spaces eet) classified as Severe	K 0	321	This plan of correction constitutes the facilities		10/27/2022

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION	(X3) DATE SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED	
		155567	B. WIN	NG		10/04/2022	
	PROVIDER OR SUPPLIER	SILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	II	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		ATE
	This deficient pract	ice could affect 20 residents in			credible allegation of		
	one smoke compart	ment.			compliance.		
					Preparation and/or execution		
	Findings include:				of this plan of correction doe	s	
	Based on observation during a tour of the facility				not constitute admission or agreement by the provider of		
		Services Director on 10/04/22			the truth of the facts alleged		
		vest-hall shower room contained			conclusions set forth in the	°'	
	-	pplies and was greater than 50			statement of deficiencies. The	ne	
		this a hazardous area. The			plan of correction is prepare		
	room was not prote	cted as a hazardous area			and/or executed solely		
		r door to the room was not			because it is required by the		
		matic closing. Based on			provisions of federal and sta	te	
		e of observation, the			law.		
		vices Director agreed the					
		ned large amount of e, was larger than 50 square			K224, Harardaya Arasa		
		or door to the room was not			K321: Hazardous Areas- Enclosure		
	self-closing.	of door to the footh was not			<u>Efficiosure</u>		
	-	viewed with the Administrator			1) Immediate actions taken fo	or	
		Services Director during the			those residents identified		
	exit conference.				No resident was found to be		
	3.1-19(b)				affected by the finding.		
					2) How the facility identified		
					other residents:		
					Visitors, staff and residents	II	
					reside at the community hav		
					the potential to be affected b	1	
					the alleged deficient practice		
					3) Measures put into place/		
					System changes:		
					Facility has assessed all mea	ins	
					noted as hazardous areas fo	r	
					need of self-closing		
					mechanisms. The west hall		
					shower room door was		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		ľ í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 10/04/	LETED
	PROVIDER OR SUPPLIE SITY PARK REHAL	R BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR NAYNE, 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
ing	REGUENTORY	RESCRIPTING INFORMATION		1710	corrected with a self-closing mechanism.	J	DATE
					4)How the corrective actions will be monitored:	5	
					The Maintenance Director/designee will audit areas noted as Hazardous areas monthly for need of self-closing mechanisms an present findings to the QAP Committee during QAPI Meetings to ensure compliance. The report will be reviewed i Quality Assurance Meeting monthly for 6 months or unt 100% compliance is achieve The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10.2	in il id. tify	
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cool * residential cook appliances such a toasters) are use	3					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155567	B. W	NG		10/04/	/2022
				CTDEET A	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
I INII\/EDG	SITV DADK DELLAR	BILITATION AND HEALTHCARE			WAYNE, IN 46825		
UNIVER	SIIT PARK KEHAD	BILITATION AND HEALTHCARE		FORT	WATNE, IN 40825		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	19.3.2.5.2						
	* cooking facilities	open to the corridor in					
	smoke compartme	ents with 30 or fewer					
	patients comply w	rith the conditions under					
	18.3.2.5.3, 19.3.2	.5.3, or					
	* cooking facilities	in smoke compartments					
	with 30 or fewer p	atients comply with					
	conditions under	18.3.2.5.4, 19.3.2.5.4.					
	Cooking facilities	protected according to					
	·	3 are not required to be					
	enclosed as haza	rdous areas, but shall not					
	be open to the co						
	18.3.2.5.1 through	n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5, 9.2.3, TIA 12-2						
		view and interview; the facility	K 0	324			10/27/2022
		f 1 kitchen fire suppression					
		ed semiannually. NFPA 96,			This plan of correction		
	·	lard for Ventilation Control and			constitutes the facilities		
		Commercial Cooking			credible allegation of		
	_	11.2.1 states Maintenance of			compliance.		
	_	ng systems and listed exhaust			Preparation and/or execution		
	_	constant or fire-activated			of this plan of correction doe	s	
	· ·	s listed to extinguish a fire in			not constitute admission or		
	_	devices. Hood exhaust			agreement by the provider of		
	•	chaust ducts shall be made by			the truth of the facts alleged	or	
		nalified, and certified person(s)			conclusions set forth in the		
	•	thority having jurisdiction at			statement of deficiencies. Ti		
	-	ths. This deficient practice			plan of correction is prepare	d	
		the kitchen and 25 residents in			and/or executed solely		
	the dining room.				because it is required by the		
	F: 1: : 1 1				provisions of federal and sta	te	
	Findings include:				law.		
	Dogad or massed	eview with the Environmental					
					K224. Cooking Facilities		
		n 10/04/22 at 11:38 a.m., the last			K324: Cooking Facilities		
					d)lmmodiate cations tales of	.=	
		vailable for review was dated ction six months after the last			1)Immediate actions taken for those residents identified	VI .	
	•	conducted. Based on			No resident was found to be		
	_	e of record review, the					
	miciview at the tim	e of fectia feview, the	1		affected by the finding.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		f '	ILDING NG	ONSTRUCTION 01	(X3) DATE COMPL 10/04/	ETED	
	PROVIDER OR SUPPLIE SITY PARK REHAI	R BILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O Environmental Ser contractors were h	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION rvices Director stated new ired to conducted hood system e system this month.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 2)How the facility identified other residents:	ATE	(X5) COMPLETION DATE
	This finding was reand Environmental exit conference.	eviewed with the Administrator I Services Director during the			Visitors, staff and residents reside at the community have the potential to be affected to the alleged deficient practice.	re Dy	
	3.1-19(b)				3) Measures put into place/ System changes: We were unable to produce a document that the inspection been completed. The sticker on the hood indicates	had	
					that the work was completed in May 2022. Inspection documentation included and completed May 2022.		
					4)How the corrective actions will be monitored: Maintenance Director/design will audit monthly to ensure	1ee	
					the semiannual inspection is completed and documentati- is present in the Life Safety Binder for 6 months. The au will be reviewed in Quality Assurance Meeting monthly ensure no changes or until	s on udit to	
					100% of education has been achieved. The QA Committed will identify any trends or patterns and make recommendations to revise to the second sec	90	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567 A. BUILDING B. WING 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 SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROVIDER PLAN OF CORRECTION CASSING PROVIDERS PL	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK REHABILITATION AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Plan of correction as indicated. (K0341 NFPA 101 SS=C Fire Alarm System - Installation	COMPLETED	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK REHABILITATION AND HEALTHCARE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION K 0341 SS=C K 0341 NFPA 101 SS=C Fire Alarm System - Installation		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK REHABILITATION AND HEALTHCARE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION K 0341 SS=C K 0341 NFPA 101 SS=C Fire Alarm System - Installation		
UNIVERSITY PARK REHABILITATION AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION FRONT WAYNE, IN 46825 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE Plan of correction as indicated. 5) Date of compliance: 10/27/22 K 0341 NFPA 101 SS=C Fire Alarm System - Installation		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROVIDERS PLAN OF CORRECTION CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE Plan of correction as indicated. 5) Date of compliance: 10/27/22 K 0341 SS=C Fire Alarm System - Installation		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Plan of correction as indicated. 5) Date of compliance: 10/27/22 K 0341 NFPA 101 SS=C Fire Alarm System - Installation	(X5)	
plan of correction as indicated. 5) Date of compliance: 10/27/22 K 0341 NFPA 101 SS=C Fire Alarm System - Installation		
K 0341 NFPA 101 SS=C Fire Alarm System - Installation indicated. Indicated. 5) Date of compliance: 10/27/22	ATE	
K 0341 NFPA 101 SS=C Fire Alarm System - Installation		
SS=C Fire Alarm System - Installation		
Bidg. 01 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 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 control panel was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. K 0341 This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction occupantive admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The	27/2022	

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Facility ID: 000459

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			î í		ONSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BU B. W	JILDING ING	01	COMPLETED 10/04/2022	
		100001	B. W			10/04/2022	-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	SILITATION AND HEALTHCARE			WAYNE, IN 46825		
(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 DEFICIENCY)		MPLETION
TAG		R LSC IDENTIFYING INFORMATION vices Director on 10/04/22 at	1	TAG	because it is required by the		DATE
		ontrol panel located in the west			provisions of federal and sta		
	-	et but the door to the cabinet			law.	.	
	opened without a ke	ey when tested. This condition					
	_	fire alarm system against					
		Based on interview at the time Environmental Services			K 341 Fire Alarm System		
	· ·	cabinet door was not properly			<u>Installation</u>		
	secured.				1)Immediate actions taken fo	r	
					those residents identified		
	-	viewed with the Administrator					
and Environmental Services Director during the				No resident was found to be			
	exit conference.				affected by the finding.		
	3.1-19(b)				2)How the facility identified		
	212 27 (2)				other residents:		
					Visitors, staff and residents		
					reside at the community hav		
					the potential to be affected be the alleged deficient practice	-	
						,	
					3) Measures put into place/ System changes:		
					System changes.		
					The fire panel box lock was		
					repaired.		
					4)How the corrective actions		
					will be		
					monitored:		
					The Maintenance		
					Director/designee will includ a note on the monthly fire dr		
					logs that the panel is locked		
					The report will be reviewed in	n	
					Quality Assurance Meeting	_	
					monthly for 6 months or unti	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 10/04/2022				
		155567	B. WI	NG		10/04/	2022
	PROVIDER OR SUPPLIER SITY PARK REHAB	ILITATION AND HEALTHCARE		1400 MI	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR 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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					100% compliance is achieved. The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10/27	ify as	
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record reversiled to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual inspectance often if requiringuirisdiction. Table must be visually insa. Control unit trouble. Remote annuncial c. Initiating devices	m is tested and maintained an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. In acceptance, maintenance addily available. FPA 70, NFPA 72 riew and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section cless otherwise permitted by etions shall be performed in a schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following spected semi-annually: ole signals ctors (e.g. duct detectors, manual at detectors, smoke detectors, siances	K 03	345	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction doe not 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 because it is required by the provisions of federal and statement and statements.	es f or he d	10/27/2022

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	,	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155567	B. WING		10/04/2022
	PROVIDER OR SUPPLIER	BILITATION AND HEALTHCARE	1400	r address, city, state, zip cod MEDICAL PARK DR WAYNE, IN 46825	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE N. AN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	This deficient pract facility.	ice affects all occupants in the		law.	
	Findings include:	iew with the Environmental		K 345 Fire Alarm System Maintenance	
	_	n 10/04/22 at 11:05 a.m., no		1)Immediate actions taken fo	or
		provided regarding a visual		those residents identified)
		re alarm system six months			
	after the annual fire	alarm inspection conducted		No resident was found to be	ļ.
		on interview at the time of		affected by the finding.	
	records review, the Environmental Services				
		sual inspection of the fire alarm		2)How the facility identified	
		after the annual fire alarm		other residents:	
	inspection was not	conducted.		Visitors staff and residents	that
	This finding was re	viewed with the Administrator		Visitors, staff and residents reside at the community have	
		Services Director during the		the potential to be affected by	
	exit conference.	2 in the same same same		the alleged deficient practice	=
	3.1-19(b)			3) Measures put into place/ System changes:	
				Compliance with meeting the	
				inspection guidelines will be	
				monitored thru the monthly Q	API
				process and meeting.	
				4)How the corrective actions	5
				will be	
				monitored:	
				The Maintenance	
				Director/designee will	
				document in the tels	
				preventative maintenance	
				system that all inspections a	
				completed per the guideline The QA Committee will	5.
				identify any trends or patter	ns
			1	on, and donated patter	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER SITY PARK REHABILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
			and make recommendations revise the plan of correction indicated.	
			5) Date of compliance: 10/27/	222
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all	K 0353	This plan of correction constitute facilities credible allegation compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreer by the provider of the truth of the facts alleged or conclusions set forth in the statement of	of of t nent he

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155567	B. WI	NG		10/04/	/2022
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
		ULITATION AND LICAL TUCADE			NAYNE, IN 46825		
UNIVERS	SIIT PARK KEHAD	SILITATION AND HEALTHCARE		FURI	/VATINE, IN 40025		
(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	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	occupants.				deficiencies. The plan of		
					correction is prepared and/or		
	Findings include:				executed solely because it is		
					required by the provisions of		
	Based on record rev	view the Administrator and			federal and state law.		
		vices Director on 10/04/22 at					
	_	vided internal inspection of					
		on stated the last inspection			K353: Sprinkler System-		
	-	07/30/15. Based on interview at			Maintenance and Testing		
		eview, the Environmental			-		
	Services Director agreed the last internal pipe				1)Immediate actions taken for		
	inspection performed has been more than 5 years.				those residents identified		
	#2. Based on record review and interview, the				No resident was found to be		
		ovide written documentation or			affected by the finding.		
	other evidence the s	sprinkler system components					
	-	and tested for 1 of 4 quarters.			2)How the facility identified ot	her	
	-	res any device, equipment or			residents':		
		compliance with this Code be					
		dance with applicable NFPA			Visitors, staff and residents th		
		nkler systems shall be properly			reside at the community have		
		dance with NFPA 25, Standard			potential to be affected by the		
	_	Γesting, and Maintenance of			alleged deficient practice		
		rotection Systems. NFPA 25,					
	-	ds shall be made for all					
	-	nd maintenance of the system			3) Measures put into place/		
	-	all be made available to the			System changes:		
		risdiction upon request. 4.3.2					
	•	s shall indicate the procedure			Compliance with meeting the		
		pection, test, or maintenance),			inspection guidelines will be	4 D.I	
	-	at performed the work, the			monitored thru the monthly Q	API	
	· ·	e. NFPA 25, 5.2.5 requires that			process and meeting.		
		vices shall be inspected hey are free of physical			4)How the corrective actions	a zi II	
		, 5.3.3.1 requires the mechanical			4)How the corrective actions to be monitored:	WIII	
		vices including, but not limited			pe monitorea.		
		gs, shall be tested quarterly.			The Maintenance		
	5.3.3.2 requires van					ant in	
	-	ow alarm devices shall be			Director/designee will docume the tels preventative maintena		
		This deficient practice could			1		
	colou semiamiuany	. This deficient practice could	1		system that all inspections are	,	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	ROVIDER OR SUPPLIER SITY PARK REHABILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR NAYNE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	affect all residents, staff, and visitors in the facility. Findings include: Based on review with the Environmental Services Director and Administrator on 10/04/22 at 11:18 a.m., there was no quarterly sprinkler system inspection report available for the third quarter (July Aug, and Sep.) of 2022. During an interview		This 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 ma recommendations to revise the plan of correction as indicated	y ıke e
	at the time of record review, the Environmental Services Director stated the facility was switching contractors and the sprinkler inspection for the third quarter was missed. This finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		5) Date of compliance: 10/27/2	22
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 penetrations through 1 of 4 smoke	K 0372		10/27/2022

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	of correction (X1) provider/supplier/clia (DENTIFICATION NUMBER (155567)	(X2) MULTIPLE COI A. BUILDING B. WING	nstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER SITY PARK REHABILITATION AND HEALTHCARE	1400 ME	DDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 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 30 residents in one two smoke compartments.		This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or executio of this plan of correction do not 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 because it is required by the provisions of federal and stallaw. K372: Subdivision of Building Spaces- Smoke Barrier Construction	es of or The ed ed eate
	Based on observation with the Environmental Services Director on 10/04/22 at 2:00 p.m., above the drop ceiling of the North Hall smoke wall there was a quarter inch gap around a dry wall patch. Based on interview at the time of observation, the Environmental Services Director agreed there was a piece of drywall covering a hole that was not properly sealed. This finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		Preparation and/or execution of this plan of correction do not 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 because it is required by the provisions of federal and stallaw. 1) Immediate actions taken for those residents identified	es of l or The ed ed eate

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	ROVIDER OR SUPPLIEF	SILITATION 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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				No resident was found to be affected by the finding.	
				2)How the facility identified other residents:	
				Visitors, staff and residents reside at the community have the potential to be affected by	e by
				the alleged deficient practice 3) Measures put into place/ System changes:	,
				Facility has assessed all identified smoke barrier corridor doorways and walls ensure no penetrations are present. Any penetrations identified in the audit will be corrected. The area above the drop ceiling of the North	
				4)How the corrective actions will be monitored:	
				The Maintenance Director/designee will inspect smoke barrier walls and corridor doors monthly for functionality. Completion inspection will be presented the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The	of to for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X: AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01		ľ í	X3) DATE SURVEY COMPLETED				
		155567	B. WI		<u>. </u>	10/04/	
	ROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE		1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
K 0500 SS=F Bldg. 01	Section 18.5 and requirements that provided K-tags, b information, along Safety Code or NF should be included Based on observation interview, the facility fired water heaters be certificates to ensure safe operating conditional 19.1.1.3.1 requires a designed constructed minimize the possible requiring the evacuar requires hot water heavery two years. The affect 25 residents in Findings include: Based on observation Services Director of the safe	- Other LKS section any LSC 19.5 Building Services are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. on, records review and by failed to ensure 4 of 4 fuel and current inspection the the water heaters were in dition. NFPA 101, Section all health facilities to be d, maintained and operated to oblity of a fire emergency ation of occupants. The State the eaters to be inspected once is deficient practice could the two smoke compartments.	K 0.	500	QA Committee will identify at trends or patterns and make recommendations to revise t plan of correction as indicated. 5) Date of compliance: 10/27/22 This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction doe not 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 because it is required by the provisions of federal and states.	he es for ne d	10/27/2022
	_	ater heater in the facility had an expiration date of			law.		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIEF	RILITATION 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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OF 2020. Based on reconsideration was the four water heater the last two years. It of the observation at Environmental Servins pection for the found and agreed the inspections were particular than the servins of the found and agreed the inspections were particular than the servins of the servin	e LSC IDENTIFYING INFORMATION ords review at 2:10 p.m., no available for review to show ers have been inspected within Based on interview at the time and records review, the vices Director stated a current our water heaters could not be the posted water heater		K500 Building Services-Oth 1)Immediate actions taken if those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents reside at the community has the potential to be affected the alleged deficient practic. 3) Measures put into place/System changes: Compliance with meeting the inspection guidelines will be monitored thru the monthly Coprocess and meeting. The inspection has been scheduled. 4)How the corrective action will be monitored: The Maintenance Director/designee will present the to the QAPI Committee during QAPI Meetings to ensure completion of any mecessary updates and compliance.	that ve by se
				The report will be reviewed	in

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	OF CORRECTION	IDENTIFICATION NUMBER 155567	A. BUILDING B. WING	01	COMPLETED 10/04/2022
	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01				Quality Assurance Meeting monthly for 6 months or unti 100% compliance is achieved. The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 10/27	d. ify as
	Code, electrical with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation of 1 electrical junt were maintained in LSC 19.5.1.1 require 9.1. LSC 9.1.2 requirequipment to complete Electrical Code. NF 314.28(3) (c) states provided with cover suitable for the conditional covers shall complete complete the conditional covers shall covers with the conditional covers shall covers with the cover suitable for the conditional covers shall covers shall covers shall covers shall covers with the cover complete covers with the covers of the conditional covers shall covers shall covers with the covers of the conditional covers shall covers shall covers of the cov	ring and equipment PA 70, National Electric tallations can continue in o hazard to life. 9.1.1, 9.1.2 on, the facility failed to ensure extion boxes in the south hall a safe operating condition. es utilities comply with Section irres electrical wiring and y with NFPA 70, National PPA 70, 2011 Edition, Article junction boxes shall be s compatible with the box and litions of use. Where used, comply with the grounding 110. This deficient practice	K 0511	This plan of correction constituthe facilities credible allegation compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed 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	n of of t ment he

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/04/2022
PROVIDER OR SUPPLIER	LILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825	
SITY PARK REHAB SUMMARY: (EACH DEFICIEN REGULATORY OR Based on observation with the Environment 10/04/22 at 2:07 p.r. south smoke barrier junction box without electrical wiring. Bathe observations, th Director acknowled was not provided wires.				tion nt. be tely ve
			4)How the corrective actions be monitored: The Maintenance Director/designee will random	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	ROVIDER OR SUPPLIER	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. The of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.3. 19.7.2.1.2, 19.7.2. Based on record reversalled to provide 1 of an emergency.	elocation Plan plan for the protection of all eir evacuation in the event priodically instructed and their duties under the plan, plan is readily available erator or with security. The the basic response required 7.2.1.2 and provides for all lan components per 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 12. 19.7.2.3 riew and interview, the facility of 1 written emergency fire proporated all items listed in	K 0711	inspect 10 junction boxes pormonth to ensure proper cover plates are present. Completed inspections will be presented the QAPI Committee during Meetings to ensure compliated The report will be reviewed Quality Assurance Meeting monthly for 6 months or unt 100% compliance is achieved The QA Committee will ider any trends or patterns and recommendations to revise plan of correction as indicated. 5) Date of compliance: 10/2	er etion of d to QAPI nce. in il ed. httify make the ed. 27/22

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		\mathbf{f}			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	A. BUILDING <u>01</u>		COMPL	
		155567	B. WI	NG		10/04/	2022
NAME OF P	ROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	BILITATION AND HEALTHCARE		FORT V	NAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1. Use of alarms.				compliance.		
		alarms to fire department.			Preparation and/or execution		
		ne call to fire department			this plan of correction does no		
	4. Response to alar				constitute admission or agree		
	5. Isolation of fire.				by the provider of the truth of the		
	6. Evacuation of in				facts alleged or conclusions so	et	
	7. Evacuation of sr	-			forth in the statement of		
	8. Preparation of II evacuation.	oors and building for			deficiencies. The plan of		
	9. Extinguishment	of fire			correction is prepared and/or		
	_	ice affects all residents, staff			executed solely because it is required by the provisions of		
	_	event of an emergency.			federal and state law.		
	and visitors in the c	vent of an emergency.			leuciai anu state iaw.		
	Findings include:				K711: Evacuation and		
	_				Relocation Plan		
	Based on records re	eview with the Environmental					
	Services Director as	nd the Administrator on			_		
	10/04/22 at 10:57 a	.m., the facility provided two fire			1)Immediate actions taken for		
	safety plans with m	issing and conflicting			those residents identified		
		neither plan addresses the					
	response to the activ	vation of a battery-operated			No resident was found to be		
		sed on interview at the time of			affected by the finding.		
		Environmental Services					
		plans will need to be			2)How the facility identified oth	ner	
		one plan with a response to			residents:		
	battery-operated sm	noke detectors.					
	TELL: C: 1:				Visitors, staff and residents the		
	_	viewed with the Administrator			reside at the community have		
		Services Director during the			potential to be affected by the		
	exit conference.				alleged deficient practice		
	3.1-19(b)				3) Measures put into place/		
	(-)				System changes:		
					Facility has reviewed and upd	ated	
					its Emergency Preparedness		
					by consolidating our plans into		
					one plan that includes a respo	nse	
					to battery operated smoke ala	rms	
					located in resident rooms		

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AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D1 B. WING STREET ADDRESS, CITY, STATE, ZIP COD		X3) DATE SURVEY COMPLETED 10/04/2022		
	PROVIDER OR SUPPLIER SITY PARK REHAB	LILITATION AND HEALTHCARE	1400 M	IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 0712	NEDA 101			4)How the corrective actions to be monitored: The Maintenance Director/designee will audit 5 semembers weekly to ensure prounderstanding and response to battery-operated smoke alarm 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure not changes or until 100% of education has been achieved. QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	staff oper to a n for e The y e
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	ay be used instead of			

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Based on record review and interview, the facility

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K 0712

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIER	SILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825	•	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF failed to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (rengineers, and adm signals and emerge varied conditions. The all staff and resident Findings include: Based on records respectives Director at 10/04/22 at 10:32 at missing documentate at 10 A third shift fire 2021. b) A third shift fire c) A second shift fire 2022. Based on interview the Environmental drills were not conconditional processor of the concondition o	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The drills on each shift for 2 of 4 1.6 states drills shall be To on each shift to familiarize The further of the following states are stated in the following stated in the fol			stitutes ation of on of s not reement of the s set	(X5) COMPLETION DATE
	3.1-19(b) 3.1-51(c)			Visitors, staff and residents reside at the community had potential to be affected by alleged deficient practice 3) Measures put into place System changes: Facility has completed re-education on expectation	ave the the	

regarding completion of fire drills.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155567	B. WING		10/04/2022
	PROVIDER OR SUPPLIER	LILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID	SUMMARY	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
				A fire drill was completed on a shifts to ensure initial compliar 4)How the corrective actions was a second control of the corrective actions where the corrective actions was a second control of the corrective actions where the corrective actions was a second control of the corrective actions where the corrective actions was a second control of the corrective actions where the corrective actions was a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective action of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective action actions we are a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions we are a second control of the corrective actions where the corrective actions we are a second control of the correction actions where the correction action actions we are a second control of the correction actions where the correction action action action action action action action action action action.	nce.
				be monitored:	VIII
				The Maintenance Director/designee will complet fire drills as indicated by the lif safety code moving forward. Completion of fire drills will be presented to the QAPI Commi during QAPI Meetings to ensu compliance. The report will b reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rev the plan of correction as indicated. 5) Date of compliance: 10/27/	fe ittee ire e e or e will and
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenal The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro annually confirm t safety and critical	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the n is not met during the pocess shall be provided to his capability for the life branches. Maintenance generator and transfer			

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switches are performed in accordance with

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED
		155567	B. WING	·	10/04/2022
		l .	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	₹		IEDICAL PARK DR	
I INII\/EDG	SITV DADK DELLAR	BILITATION AND HEALTHCARE		WAYNE, IN 46825	
UNIVERS	DITT FARR NETIAL	BILITATION AND HEALTHCARE	FORT	WATNE, IN 40025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	NFPA 110.				
	Generator sets are	e inspected weekly,			
	exercised under lo	oad 30 minutes 12 times a			
	year in 20-40 day	intervals, and exercised			
		onths for 4 continuous hours.			
		ider load conditions include			
	a complete simula	ated cold start and			
	automatic or man	ual transfer of all EES			
		nducted by competent			
	•	nance and testing of stored			
		rces (Type 3 EES) are in			
		NFPA 111. Main and feeder			
		e inspected annually, and a			
		dically exercising the			
		tablished according to			
		uirements. Written records			
		nd testing are maintained			
		ble. EES electrical panels			
		arked, readily identifiable,			
	•	n normal power circuits.			
		ssibility of damage of the			
		source is a design			
	consideration for r				
		(NFPA 99), NFPA 110,			
	NFPA 111, 700.10	` ,	17.0010		10/27/2022
		vation and interview, the	K 0918		10/27/2022
	•	sure 1 of 1 emergency task		This plan of correction assets	utoo
		vided with a battery backup		This plan of correction constitu	
	-	010 Edition at section 7.3.1 or Level 2 EPS equipment		the facilities credible allegation	11 01
	location(s) shall be			compliance.	of
	` '	provided with nergency lighting. This		Preparation and/or execution this plan of correction does no	
		ould affect all residents in the		constitute admission or agree	
	facility.	Said affect aff residents in the		by the provider of the truth of	
	iacinty.			facts alleged or conclusions s	
	Findings include:			forth in the statement of	- Cι
	i manigo metude.			deficiencies. The plan of	
	Rased on observativ	ons during a tour of the facility		correction is prepared and/or	
		ental Services Director on		executed solely because it is	
		m., there was no emergency		required by the provisions of	
	10/04/22 at 1.13 p.1	ii., there was no emergency		Ledanea by the brosisions of	l

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	LIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE : COMPL 10/04/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	₹	•		ADDRESS, CITY, STATE, ZIP COD	•	
UNIVER	SITY PARK REHAE	BILITATION AND HEALTHCARE			EDICAL PARK DR WAYNE, IN 46825		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		the at the generator. Based on time of record review, the			federal and state law.		
		vices Director agreed there was					
		light at the generator.			K918 Essential Electric System	m	
	no suitery powered	ingili de die generatori			Maintenance and Testing	<u></u>	
	#2. Based on record	d review and interview, the			<u></u>		
		intain a complete written record			1)Immediate actions taken for		
	of monthly generate	or load testing for 1 of 12			those residents identified:		
	-	inspection for 5 of 52 weeks.					
	_	(a) of 2012 NFPA 99 requires			No resident was found to be		
		the generator serving the			affected by the finding.		
		al system to be in accordance					
with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110				2) How the facility identified of	ther		
		el generator sets in service to be			residents:		
	_	nce monthly, for a minimum of			Visitors, staff and residents ha	ave	
		n 8.4.1 requires an Emergency			that reside at the community h		
		em (EPSS) including all			the potential to be affected by		
		nents, shall be inspected			alleged deficient practice.		
	weekly and exercis	ed monthly. Chapter 6.4.4.2 of					
	_	a written record of inspection,			3) Measures put into place/		
	_	ising period, and repairs for the			System changes:		
		ularly maintained and available					
	for inspection by th				New Maintenance Director wil	l be	
	l *	leficient practice could affect all			educated on preventative		
	occupants.				maintenance program and wil ensure inspection of generato		
	Findings include:				completed weekly and load te		
	i manigs merade.				monthly and that a battery	J.	
	Based on records re	eview with the Environmental			powered light is present and		
	Services Director o	n 10/04/22 at 10:47 a.m., no			operational at the generator.		
	documentation was	available for the month of					
		show the generator set in			The light is now present and		
		ed at least once monthly, for a			operational. See corner object		
		nutes. Also, the generator			between glass window and br	ick	
		og showed the last weekly			wall.		
	_	ducted on 09/02/22 and no					
		etions were conducted since. ew at the time of record review,			4) How the corrective setting	النيم	
		Services Director stated the			4) How the corrective actions be monitored:	WIII	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 [ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
	09/02/22 were not of Maintenance Direct This finding was re-			The Maintenance Director/designee will preselectrical systems to the Quality Assuration of the selectrical systems to the Quality Assuration of the results of these audits reviewed in Quality Assuration Meeting monthly for 6 monuntil 100% compliance is achieved. The QA Committidentify any trends or patter make recommendations to the plan of correction as indicated. 5) Date of compliance: 10	API eetings will be nce ths or tee will rns and revise
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity	ent - Power Cords and ent - Power Strips in ent ent ent ent ent ent ent ent ent en			

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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 10/04/2022	
	PROVIDER OR SUPPLIER SITY PARK REHABILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations with the Environmental Services Director on 10/04/22 at 1:30 p.m., a power-strip in room 408 was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Environmental Services Director agreed a power-strip was in use in resident care area and did not meet 1363A or 60601-1. This finding was reviewed with the Administrator and Environmental Services Director during the exit conference. 3.1-19(b)	K 0920	This plan of correction constituthe facilities credible allegation compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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. K920 Electrical Equipment - Power Cords and Extension Corrections taken for those residents identified: No resident was found to be affected by the finding. 2) How the facility identified or residents:	of of ot ment the et	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155567	B. WING		10/04/2022		
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			EDICAL PARK DR		
UNIVERS	SITY PARK REHAE	BILITATION AND HEALTHCARE			VAYNE, IN 46825		
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	DATE
					Visitors, staff and residents have		
					that reside at the community h		
				the potential to be affected by the		the	
					alleged deficient practice.		
			3) Measures r		3) Measures put into place/		
					System changes:		
					Chaff advanting	-14-	
					Staff education was completed		
					ensure understanding of using	-	
					approved medical grade power strips in resident rooms.	<i>3</i> 1	
					Sulps in resident rooms.		
					The Maintenance Director and	d/or	
					designee will conduct an audi	t of	
					10 rooms a week to ensure ro	oms	
					are free of power cords.	ļ	
					The power cord in 408 was	ļ	
					replaced with one that meeting	as	
					the appropriate UL rating.]	
					1) How the corrective setimes	will	
					4) How the corrective actions be monitored:	WIII	
					Do monitorea.		
					The Maintenance		
					Director/designee will present		
					electrical systems to the QAP	l	
					Committee during QAPI Meeti	ings	
					to ensure completion and		
					compliance.		
					The results of these audits wil	l he	
					reviewed in Quality Assurance		
					Meeting monthly for 6 months		
					until 100% compliance is		
					achieved. The QA Committee	will	
					identify any trends or patterns	and	
					make recommendations to rev		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

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		10/04/2022		
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		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 APPROPRIAT	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				the plan of correction as			
				indicated.			
				5) Date of compliance: 10/27	/22		
				-			

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