STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567 NAME OF PROVIDER OR SUPPLIER			A. BUILDI B. WING	NG REET A	DDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 11/16/2022	
UNIVER	SITY PARK REHAI	BILITATION AND HEALTHCARE			/AYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0037 SS=C Bldg	441.184(d)(1), 484 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 485 486.360(d)(1), § §403.748(d)(1), § §441.184(d)(1), § §445.68(d)(1), § (1), §485.920(d)(§491.12(d)(1). *[For RNCHIs at Hospitals at §482 HHAs at §484.10 §485.727, OPOs at §491.12:] (1) Training prog all of the following (i) Initial training i policies and proc existing staff, indiunder arrangeme consistent with the (ii) Provide emergate least every 2 y (iii) Maintain docupreparedness trae (iv) Demonstrate emergency proceed (v) If the emerger and procedures at [facility] must consupdated policies *[For Hospices and The hospice must (i) Initial training i policies and procedures at the hospice must (ii) Initial training i policies and procedures and procedures and procedures at the hospice must (ii) Initial training i policies and procedures and p	ram (416.54(d)(1), §418.113(d)(1), (460.84(d)(1), §482.15(d)(1), (83.475(d)(1), §484.102(d)(1), (485.625(d)(1), §485.727(d), (485.625(d)(1), §485.727(d), (485.625(d)(1), §486.360(d)(1), (485.625(d)(1), §486.360(d)(1), (485.625(d)(1), §486.360(d)(1), (485.625(d)(1), §486.360(d)(1), (485.625(d)(1), §486.360(d)(1), (485.625(d)(1), §486.360, RHC/FQHCs (486.360, RHC/FQHCs), (4					
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Goran Prentoski RDO 11/29/2022

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

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PSWI22 Facility ID: 000459 If continuation sheet Page 1 of 17

PRINTED: 12/08/2022

DEPARTMENT		FORM APPROVED OMB NO. 0938-039						
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	ì í	JILDING	ONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED 11/16/2022	
	PROVIDER OR SUPPLIE	R BILITATION AND HEALTHCARE	<u> </u>	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
	providing service: consistent with th (ii) Demonstrate semergency proces (iii) Provide emer at least every 2 y (iv) Periodically resemended in the procedures of the procedures. *[For PRTFs at & program. The PR following: (i) Initial training if policies and procedures of the proce	gency preparedness training ears. eview and rehearse its predness plan with hospice ding nonemployee staff), hasis placed on carrying out eccessary to protect patients mentation of all emergency ining. Incy preparedness policies are significantly updated, the induct training on the						

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

emergency procedures.

preparedness training.

policies and procedures.

(iv) Maintain documentation of all emergency

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

Page 2 of 17

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155567	B. WING		11/16/2022
NAME OF F			STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIER	R	1400 M	MEDICAL PARK DR	
UNIVERS	SITY PARK REHAE	BILITATION AND HEALTHCARE	FORT	WAYNE, IN 46825	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	60.84(d):] (1) The PACE			
		t do all of the following:			
		n emergency preparedness edures to all new and			
		viduals providing on-site			
	_	rangement, contractors,			
		volunteers, consistent with			
	their expected role				
	-	jency preparedness training			
	at least every 2 ye	· · · · · · · · · · · · · · · · · · ·			
	(iii) Demonstrate s	staff knowledge of			
	emergency proce	dures, including informing			
	participants of wh	at to do, where to go, and			
		n case of an emergency.			
	' '	ımentation of all training.			
		ncy preparedness policies			
	-	re significantly updated, the			
		uct training on the updated			
	policies and proce	edures.			
	*[For LTC Facilitie	es at §483.73(d):] (1)			
	Training Program	. The LTC facility must do all			
	of the following:				
	, ,	n emergency preparedness			
		edures to all new and			
	_	viduals providing services			
		nt, and volunteers,			
	consistent with the				
	, ,	ency preparedness training			
	at least annually.	mentation of all emergency			
	preparedness trai				
		staff knowledge of			
	emergency proce	_			
	*[For CORFs at &	485.68(d):](1) Training. The			
	CORF must do al				
		raining in emergency			
		icies and procedures to all			
		staff, individuals providing			

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 3 of 17

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING		COMPL	LETED
		155567	B. WIN	NG		11/16	/2022
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			EDICAL PARK DR		
UNIVERS	SITY PARK REHAE	BILITATION AND HEALTHCARE			VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		rangement, and volunteers,					
		eir expected roles.					
	(ii) Provide emergency preparedness training at least every 2 years.(iii) Maintain documentation of the training.						
	(iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of						
	1 ' '	_					
		dures. All new personnel and assigned specific					
		garding the CORF's					
	1	vithin 2 weeks of their first					
		ning program must include					
		ocation and use of alarm					
		als and firefighting					
	equipment.	ale and menghang					
	1	ncy preparedness policies					
	. ,	re significantly updated, the					
		uct training on the updated					
	policies and proce	- · · · · · · · · · · · · · · · · · · ·					
	*[For CAHs at §48	35.625(d):] (1) Training					
	program. The CAI	H must do all of the					
	following:						
		n emergency preparedness					
	1 '	edures, including prompt					
	reporting and exti						
	1 '	nere necessary, evacuation					
	l :	nnel, and guests, fire					
	I	ooperation with firefighting					
		orities, to all new and					
	I -	viduals providing services					
	1	nt, and volunteers,					
		eir expected roles.					
	' '	ency preparedness training					
	at least every 2 ye						
	1 ' '	mentation of the training.					
	1 ' '	staff knowledge of					
	emergency proce						
	. ,	ncy preparedness policies					
		re significantly updated, the					
	L CALL HIUST COLLOR	ct training on the updated	1				1

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

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

Page 4 of 17

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/16/2022	
	PROVIDER OR SUPPLIEI SITY PARK REHAE	RILITATION 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 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 CMHC must emergency prepare procedures to all individuals provid arrangement, and their expected rol documentation of must demonstrate emergency proce CMHC must prov preparedness trailed to conduct ar Emergency Prepare facility must do all training in emerger procedures to all not individuals providi and volunteers, corroles; (ii) Provide etraining at least and documentation of a training; (iv) Demonstraining; (iv) Demonstraining; (iv) Demonstraining; (iv) Demonstraining; (iv) Demonstraining; (iv) Demonstraining include: Based on record reprinciples at 2.43 of annual EEP staff of 2022, but there wif staff could demonstraining and intervities	provide initial training in redness policies and new and existing staff, ing services under levolunteers, consistent with es, and maintain the training. The CMHC estaff knowledge of dures. Thereafter, the ide emergency ning at least every 2 years. view and interview, the facility mula training for the edness Program (EPP). The LTC of the following: (i) Initial recypreparedness policies and ew and existing staff, ing services under arrangement, issistent with their expected emergency preparedness anally; (iii) Maintain lemergency preparedness enstrate staff knowledge of the interest in accordance with 42 CFR deficient practice could affect	E 0	037	This plan of correction constitute facilities credible allegation compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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. The facility requests paper compliance for this citation. E037 Emergency Preparednet Training Plan 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding.	of of of ot one of ot	11/30/2022

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 5 of 17

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/16/2022	
	PROVIDER OR SUPPLIER	SILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY 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	
	the training) was as any other way to de the Receptionist sta any other way to de conducted. The Ma Regional Maintena Receptionist resport to be conducted. The finding was revoluted. The finding was revoluted the Regional Clinic conference.	R LSC IDENTIFYING INFORMATION sked if a test was conducted or emonstrate Knowledge, and sted there was not a test nor emonstrate knowledge intenance Director and the nice Director acknowledge the nise and stated testing will need wiewed with the Maintenance nal Maintenance Director, and ral Director during the exit s cited on 10/04/22. The facility a systemic plan of correction			ner at the and gnee bers vill the nee are sary lity or 6	
				is achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as indicated. 5) Date of compliance:	ee erns o	

Event ID: PSWI22 Facility ID: 000459 Page 6 of 17 If continuation sheet

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155567		A. BUILDING B. WING	onstruction 	COMPLETED 11/16/2022		
	PROVIDER OR SUPPLIER	ILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.6 (e) Emergency and The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency general generator must be the location require Care Facilities Cool Interim Amendment 12-4, TIA 12-5, an Code (NFPA 101 a Amendments TIA and TIA 12-4), and structure is built or structure or buildin 482.15(e)(2), §483 Emergency genera The [hospital, CAI- implement the emi inspection, testing requirements foun	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. nd the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new of when an existing				

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

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

Page 7 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155567	B. WING		11/16/2022	
NAME O	F PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
UNIVE	RSITY PARK REHAE	BILITATION AND HEALTHCARE		MEDICAL PARK DR WAYNE, 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 APPROPRI	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Emergency gener and LTC facilities source to power endance a plan for he power systems operation of the systems of the standards incertain this section are appreference by the Effect Register in Standards from You may inspect and Information Reson Boulevard, Baltim	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain the sources listed below. a copy at the CMS curce Center, 7500 Security ore, MD or at the National				
	(NARA). For informathis material at NA go to:	eords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code				
	_of_federal_regul If any changes in incorporated by re document in the F announce the cha (1) National Fire F Batterymarch Par Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Heal	ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a Federal Register to anges. Protection Association, 1 k, 9, www.nfpa.org,				
	(ii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NI 2012.	ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7				

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 8 of 17

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155567	B. W	NG		11/16	/2022
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			EDICAL PARK DR		
LINIIVER!	SITV DARK REHAE	BILITATION AND HEALTHCARE			NAYNE, IN 46825		
ONIVEIN	- TANKINENAL	DETATION AND TEACHTOAKE		TORT			
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2013.						
	' '	FPA 99, issued August 1,					
	2013.						
	, ,	FPA 99, issued March 3,					
	2014.						
		fe Safety Code, 2012					
	edition, issued Au	_					
	(VIII) TIA 12-1 to N 11, 2011.	IFPA 101, issued August					
	(ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.						
	,	FPA 101, issued October					
	22, 2013.						
	(xiii) NFPA 110, S	tandard for Emergency and					
		ystems, 2010 edition,					
	including TIAs to	chapter 7, issued August 6,					
	2009						
		eview and interview, the facility	E 00	041	This plan of correction constitu	utes	11/30/2022
		the emergency power system			the facilities credible allegation	n of	
	_	in the Health Care Facilities			compliance.		
		and Life Safety Code (LSC) in			Preparation and/or execution of		
		CFR 483.73(e)(2). This			this plan of correction does no		
	deficient practice co	ould affect all occupants.			constitute admission or agreer		
	F' 1' ' 1 1				by the provider of the truth of t		
	Findings include:				facts alleged or conclusions se	₽l	
	Rosed on records re	eview with the Maintenance			forth in the statement of deficiencies. The plan of		
		egional Maintenance Director			correction is prepared and/or		
		p.m., the generator lacked			executed solely because it is		
		g required by LSC and NFPA			required by the provisions of		
		rview at the time of record			federal and state law.		
		nmental Services Director stated			The facility requests paper		
		nissing some of the required			compliance for this citation.		
	testing.	3 4					
					E041 Hospital CAH and LTC		
	The finding was rev	viewed with the Maintenance			Emergency Power		
	_	nal Maintenance Director, and]		
	the Regional Clinic	al Director during the exit			1)Immediate actions taken for		

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 9 of 17

12/08/2022 PRINTED:

DEPARTMENT		RM APPROVED					
	MEDICARE & MEDIC		(V2) M	III TIDI E CO	ONCEDICEION		B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155567	B. W.			11/16/	
		193907	D. W.	_		11/10/	2022
NAME OF F	ROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP COD 1400 MEDICAL PARK DR				
UNIVERS	SITY PARK REHAE	BILITATION AND HEALTHCARE	FORT WAYNE, 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	conference.				those residents identified		
	This deficiency was cited on 10/04/22. The facility failed to implement a systemic plan of correction to prevent recurrence.				No resident was found to be		
					affected by the finding.		
	to provide a				2)How the facility identified oth residents:	ner	
					Visitors, staff and residents that reside at the community have		
					potential to be affected by the	uie	
					alleged deficient practice		
					Measures put into place/ System changes:		
					Facility has reviewed and completed monthly load testing meet the requirements.	g to	
					4)How the corrective actions to be monitored:	will	
					The Maintenance Director/designee will present monthly load report to the QAF Committee 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 identify any trends or patterns and ma recommendations to revise the	on y ke	

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

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

plan of correction as indicated.

5) Date of compliance:

11/30/2022

Page 10 of 17

PRINTED: 12/08/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155567	B. W	ING		11/16	/2022
	PROVIDER OR SUPPLIER			1400 N	ADDRESS, CITY, STATE, ZIP COD MEDICAL PARK DR		
UNIVER	SILY PARK REHAE	BILITATION AND HEALTHCARE		FURI	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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
K 0321	NFPA 101						
SS=E	Hazardous Areas						
Bldg. 01	Hazardous Areas						
		are protected by a fire					
		our fire resistance rating					
	1 '	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
	option is used, the areas shall be separated from other spaces by smoke resisting						
	partitions and doors in accordance with 8.4.						
	Doors shall be se						
		and permitted to have					
	_	applied protective plates that					
		inches from the bottom of					
	the door.	menes nem me bettem er					
	Describe the floor	and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	N/A					
	a. Boiler and Fuel	-Fired Heater Rooms					
	, -	er than 100 square feet)					
		nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)						
	e. Trash Collectio						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	· ·					
	,	classified as Severe					
	Hazard - see K32	,	17.0	221	This plan of a secretical and an		11/20/2022
		on and interview, the facility	K 0	521	This plan of correction constit		11/30/2022
		f 2 bathing rooms with large			the facilities credible allegation	11 01	
		stible storage and greater than protected as a hazardous area.			compliance.	of	
		protected as a nazardous area. ice could affect 20 residents in			Preparation and/or execution		
	This deficient pract	ice could affect 20 festuellis III			this plan of correction does no	JL	

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

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

Page 11 of 17

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	ETED
		155567	B. WING			11/16/	2022
			ST	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			EDICAL PARK DR		
UNIVERS	SITY PARK REHAB	SILITATION AND HEALTHCARE			VAYNE, IN 46825		
	Т			-	, -		ave:
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	one smoke compart	R LSC IDENTIFYING INFORMATION	17	AG		mont	DATE
	one smoke compart	ment.			constitute admission or agreer		
	Findings include:				by the provider of the truth of t		
	Findings include.				facts alleged or conclusions se forth in the statement of	ŧι	
	Raced on observativ	on with the Maintenance			deficiencies. The plan of		
		2 at 4:08 p.m., the west-hall			correction is prepared and/or		
	shower room contained over 10 boxes of supplies				executed solely because it is		
	and was greater than 50 square feet making this a				required by the provisions of		
	and was greater than 50 square feet making this a hazardous area. The room was not protected as a				federal and state law.		
		ause the corridor door to the			The facility requests paper		
		closing due to a Sanitary			compliance for this citation.		
		ween the door and door frame			compilation for this situation.		
		from closing. Based on			K321: Hazardous Areas-		
		e of observation, the			Enclosure		
		for agreed the shower room					
		ount of combustible storage,			1) Immediate actions taken fo	or	
	_	square feet, and the corridor			those residents identified		
		se due to a Sanitary Napkin					
		door and frame. The			No resident was found to be		
		or did remove the Sanitary			affected by the finding.		
	Napkin and the doo	r did close.			, c		
					2) How the facility identified ot	her	
	The finding was rev	viewed with the Maintenance			residents:		
	Director, the Region	nal Maintenance Director, and			Visitors, staff and residents that	at	
	the Regional Clinic	al Director during the exit			reside at the community have	the	
	conference.				potential to be affected by the		
					alleged deficient practice		
	I -	s cited on 10/04/22. The facility					
	_	a systemic plan of correction			3) Measures put into place/		
	to prevent recurrence	ce.			System changes:		
					Facility has assessed all mea		
					noted as hazardous areas for	need	
					of self-closing mechanisms.		
					A) 11	•11	
					4)How the corrective actions v	VIII	
					be monitored:		
					The Maintenance		
					Director/designee will audit 5		
					areas noted as Hazardous are	28	
					0.545 110150 45 04/4101015 215	.03	

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2022
	PROVIDER OR SUPPLIER	SILITATION AND HEALTHCARE	1400 M	ADDRESS, CITY, STATE, ZIP COD IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and R Evacuation and R			monthly and present findings the QAPI Committee during Q Meetings to ensure compliant 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 marecommendations to revise th plan of correction as indicated 5) Date of compliance: 11/30/2022	API . y ske e
	There is a written patients and for the of an emergency. Employees are percentaged in the with telephone op plan addresses the of staff per 18/19. Of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2. Based on record reversible for the patients of the provide 1 of the patients of the provide 1 of the patients of the provide 1 of the patients of	plan for the protection of all peir evacuation in the event eriodically instructed and in their duties under the plan, plan is readily available erator or with security. The erator or with security. The erator 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, 19.7.2.3 given and interview, the facility of 1 written emergency fire	K 0711	This plan of correction constituthe facilities credible allegation	
	NFPA 101, Section 1. Use of alarms. 2. Transmission of	alarms to fire department. ne call to fire department		compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of facts alleged or conclusions so	ot ment the

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 13 of 17

12/08/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/16/2022 155567 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1400 MEDICAL PARK DR UNIVERSITY PARK REHABILITATION AND HEALTHCARE FORT WAYNE. IN 46825 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 5. Isolation of fire. forth in the statement of 6. Evacuation of immediate area. deficiencies. The plan of 7. Evacuation of smoke compartment. correction is prepared and/or 8. Preparation of floors and building for executed solely because it is evacuation. required by the provisions of 9. Extinguishment of fire. federal and state law. This deficient practice affects all residents, staff The facility requests paper and visitors in the event of an emergency. compliance for this citation. Findings include: K711: Evacuation and Relocation Plan Based on records review with the Maintenance Director and the Regional Maintenance Director 1)Immediate actions taken for on 11/16/22 at 3:57 p.m., the fire safety plan was those residents identified missing (#4) Response to all alarms. The provided fire safety plan did not address the response to No resident was found to be the activation of a battery-operated smoke alarms. affected by the finding. Based on interview at the time of records review, the Maintenance Director and the Regional 2)How the facility identified other Maintenance Director stated the facility does residents: have battery-operated smoke alarms and the fire safety plan did not address the response to the Visitors, staff and residents that activation of battery-operated smoke alarms. reside at the community have the potential to be affected by the The finding was reviewed with the Maintenance alleged deficient practice Director, the Regional Maintenance Director, and the Regional Clinical Director during the exit 3) Measures put into place/ conference. System changes: This deficiency was cited on 10/04/22. The facility Facility has reviewed and updated failed to implement a systemic plan of correction its Emergency Preparedness Plan to prevent recurrence. by consolidating our plans into one plan that includes a response to battery operated smoke alarms located in resident rooms 4)How the corrective actions will be monitored:

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

PSWI22 Event ID:

Facility ID: 000459

The Maintenance

If continuation sheet

Page 14 of 17

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155567	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>		E SURVEY LETED 6/2022
	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. der load conditions include		Director/designee will aud members weekly to ensu understanding and responsattery-operated smoke a 6 months. The audit will reviewed in Quality Assur Meeting monthly to ensur changes or until 100% of education has been achie QA Committee will identife trends or patterns and material recommendations to revisible plan of correction as indicated by the property of th	re proper nse to a alarm for be rance re no eved. The y any ake se the	

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

Event ID:

PSWI22

Facility ID: 000459

If continuation sheet

Page 15 of 17

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	ETED	
155567		155567			11/16/	2022	
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD EDICAL PARK DR		
UNIVERSITY PARK REHABILITATION AND HEALTHCARE				l			
UNIVERS	DIT FARN KEHAD	BILITATION AND HEALTHCARE		FORT	WAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY)	
	energy power sou	rces (Type 3 EES) are in					
	accordance with NFPA 111. Main and feeder						
	circuit breakers are inspected annually, and a						
		dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels				ļ	
		arked, readily identifiable,					
		n normal power circuits.					
	· ·	ssibility of damage of the					
		source is a design					
	consideration for r	<u> </u>					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	•					
		view and interview, the facility	K 0	918			11/30/2022
		complete written record of	110	710	This plan of correction constitu	utes	11/30/2022
		load testing for 1 of 12 months			the facilities credible allegation		
		ion for 5 of 52 weeks. Chapter			compliance.		
		12 NFPA 99 requires monthly			Preparation and/or execution	of	
	, ,	ator serving the emergency			this plan of correction does no		
		be in accordance with NFPA			constitute admission or agree		
	•	or Emergency and Standby			by the provider of the truth of t		
		hapter 8. NFPA 110 8.4.2			facts alleged or conclusions se		
		erator sets in service to be			forth in the statement of	,	
		nce monthly, for a minimum of			deficiencies. The plan of		
		a 8.4.1 requires an Emergency			correction is prepared and/or		
		em (EPSS) including all			executed solely because it is	ļ	
		nents, shall be inspected			required by the provisions of		
		ed monthly. Chapter 6.4.4.2 of			federal and state law.	ļ	
	-	a written record of inspection,			The facility requests paper	ļ	
	-	ising period, and repairs for the			compliance for this citation.	ļ	
	-	alarly maintained and available			Compliance for this citation.	ļ	
	for inspection by th				K918 Essential Electric Syste	m	
		leficient practice could affect all			Maintenance and Testing		
	occupants.	controlled practice could affect all			I wantenance and resung	ļ	
	occupants.				1)Immediate actions taken for	ļ	
	Findings include:				those residents identified:	ļ	
	i manigo metade.				unose residents identined.	ļ	
	Based on records re	eview with the with the			No resident was found to be		

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

Event ID:

PSWI22 Facility ID: 000459

If continuation sheet Page 16 of 17

PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building 01		COMPLETED		
155567		155567	B. WING		11/16/2022		
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	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		
	Maintenance Direct	tor and the Regional		affected by the finding.			
	Maintenance Direct	tor on 11/16/22 at 2:47 p.m., no					
	documentation was	available for the month		2) How the facility identified of	ther		
	October 2022 to she	ow the generator set in service		residents:			
	was exercised at lea	ast once monthly, for a					
	minimum of 30 min	nutes. Also, no documentation		Visitors, staff and residents ha	ave		
	was provided to show the weekly generator			that reside at the community h	nave		
	inspection were conducted since the LSC survey			the potential to be affected by	the		
	on 10/04/22. Based on an interview at the time of			alleged deficient practice.			
	record review, the I	Maintenance Director and the					
	Regional Maintena	nce Director stated all		3) Measures put into place/			
	inspections and test	ing were conducted but the		System changes:			
	documentation coul	ld not be found.		Maintenance Director or Des	ignee		
				have completed weekly and			
	The finding was rev	viewed with the Maintenance		monthly generator inspections	s and		
	Director, the Region	nal Maintenance Director, and		will continue moving forward.			
	the Regional Clinic	al Director during the exit					
	conference.			4) How the corrective actions	will		
				be monitored:			
	This deficiency was	s cited on 10/04/22. The facility		The Maintenance			
	failed to implement	a systemic plan of correction		Director/designee will present			
	to prevent recurrence	ce.		electrical systems to the QAP	1		
				Committee during QAPI Meet	ings		
				to ensure completion and			
				compliance.			
				· The results of these au	dits		
				will be reviewed in Quality			
				Assurance Meeting monthly for	or 6		
				months or until 100% complia	nce		
				is achieved. The QA Committee	ee		
				will identify any trends or patte			
				and make recommendations t	o		
				revise the plan of correction a	s		
				indicated.			
				5) Date of compliance:			
				11/30/2022			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PSWI22 Facility ID: 000459 If continuation sheet Page 17 of 17