STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING -- B. WING	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/15/25 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 At this Emergency Preparedness survey, University Park Rehabilitation and Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 104 and had a census of 62 at the time of this survey. Quality Review completed on 05/19/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/15/25 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 At this Life Safety Code survey, University Park Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brent Swan	Executive Director	06/01/2025

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 104 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a garage providing facility services including the storage of maintenance supplies that was not sprinklered. Quality Review completed on 05/19/25			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on records review, interview, and observations, the facility failed to ensure cleaning of 60 of 60 battery operated smoke alarms in resident rooms was conducted according to manufacturer's instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions.	K 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected. What measures will be put into	06/01/2025

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	This deficient practice affects all residents. Findings include: Based on observations with the Maintenance Director and Administrator on 05/15/25 between 11:30 a.m. and 12:45 p.m., each resident room contained a battery-operated smoke alarm. Based on records review at 10:13 a.m., according to the smoke alarm manufacturer's instructions, "the smoke alarms should be tested weekly and cleaned monthly." Upon review of the Smoke Detector testing documentation, the itemized list indicated the resident room's battery-operated smoke alarms are tested weekly, but did not indicate if the alarms were cleaned monthly. Based on an interview at 11:30 a.m., the Maintenance Director stated the alarms are only cleaned if the alarms look dirty and are not cleaned monthly according to manufacturer's instructions. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director or designee will clean all battery powered smoke alarms on a monthly basis and as directed per manufacturer guidelines. Facility documentation and tracking system (TELS) has been updated to include routine monthly check offs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? TELS report tracking smoke detector cleaning will be provided as part of monthly QAPI meeting x 3 months until 100% completion is maintained.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interviews, the facility failed to provide grease drip trays for 1 of 1 Kitchens. Cooking equipment is protected in accordance with NFPA 96, 6.2.4, Section 6.2.4.1 states that grease filters shall be equipped with a grease drip tray beneath their lower edges. Section 6.2.4.2 states grease drip trays shall be kept to the minimum size needed to collect grease. Section 6.2.4.3 states that grease drip trays shall be pitched to drain into an enclosed metal	K 0324	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **How other residents having the**	06/01/2025

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	container having a capacity not exceeding 3.8 L (1 gal). This deficient practice could affect staff in the kitchen and 50 residents in the dining room. Findings include: Based on observation with the Maintenance Director and Administrator on 05/15/25 at 12:11 p.m., the kitchen was provided with a UL 300 hood system with grease filters but the place for the grease drip tray was missing the tray. Based on interviews at 12:11 p.m., the Maintenance Director, Administrator, and the Dietary Manager stated it is unknown what happened to the drip tray and will have to order a new one. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Grease drip tray was installed by Maintenance Director on 5/30/25. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Grease drip tray placement will be verified as part of routine dietary sanitation audits completed by Director of Food Services. Findings of sanitation audits will be provided during monthly QAPI meeting x 3 months until 100% placement is obtained.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section	K 0345	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/01/2025

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	14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals. b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director and Administrator on 05/15/25 at 10:08 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 02/05/25. Based on an interview at 10:08 a.m., the Maintenance Director stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		No residents were identified as being affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director completed a visual inspection of the fire system on 5/22/25. Additional visual inspection has been scheduled for August by independent contractor service. Semi-Annual inspections have been additionally scheduled through the Maintenance Director or designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Semi-annual visual inspections and completion certifications will be discussed at monthly QAPI meetings until 12 months of compliance is achieved.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric			

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	Based on observation and interview, the facility failed to ensure 1 of 1 receptacles within 6 feet from a water source were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 30 residents on the 200-hall. Findings include: Based on observations with the Maintenance	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No residents had the potential to be affected as the outlet was in a non-resident area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director placed a fixed cap on the water line noted during survey to be functional. Water line was tested for leaks and determined to be fully sealed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Maintenance director will monitor cap for future leaks or dislodgement x 3 months until 100% compliance is achieved. Area will be discussed in monthly	06/01/2025

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	Director and Administrator on 05/15/25 at 11:27 a.m., the old mop sink on the 200-hall had a faucet removed but there was a non-GFCI receptacle above a copper pipe with a shut off valve. When the valve was turned water did flow out of the pipe, therefore making the area a wet location. The receptacle measured 11 inches from the water source and when tested with a testing device the receptacle did not trip or break the electrical circuit. Based on an interview at 11:27 a.m., the Maintenance Director agreed the receptacle was by a water source and was not GFCI protected. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		QAPI meetings until threshold is obtained.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff, and visitors in the event of an emergency. Findings include:	K 0711	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. **What measures will be put into**	06/01/2025

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	Based on records review with the Maintenance Director and Administrator on 05/15/25 at 9:45 a.m., the facility's fire safety plan did not explain how to operate a fire extinguisher and did not identify types of fire extinguishers in the facility. Based on an interview at 9:45 a.m., the administrator looked through the plan and stated the aforementioned information was not in the fire safety plan. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Administrator updated the Emergency Preparedness Binders to include updated Fire Safety Plan that instructs staff on the proper methods of utilizing fire extinguishers via the PASS method. Maintenance Director has educated staff members on the proper methods of utilizing a fire extinguisher per the updated Fire Safety Plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Annual education with all staff has been implemented through routine inservices to ensure 100% compliance. Human Resources Director or their designee will track and monitor employees to verify all employees remain current on Fire Safety Plan. Human Resources Director will report progress to QAPI meeting x 3 months until 100% compliance is achieved.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 2 smoking areas were	K 0741	**What corrective action(s) will be accomplished for those**	06/01/2025

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	maintained by disposing of cigarette butts in metal or noncombustible containers with self-closing cover devices. This deficient practice could affect staff outside the service exit. Findings include: Based on observation with the Maintenance Director and Administrator on 05/15/25 at 12:25 p.m., in the staff smoking area outside the service hall exit there were over 20 cigarette butts disposed into two trash cans containing combustible materials. Also, the area was not provided with a metal or noncombustible container with a self-closing cover to properly dispose of cigarette butts. Based on interview at 12:25 p.m., the Maintenance Director agreed there were cigarette butts in two plastic trash cans and the area did not contain a metal or noncombustible container with a self-closing cover. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		**residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No residents have the potential to be affected as the alleged deficiency was found in an area residents could not access. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** New fully enclosed and locking smoking receptacles have been added to the employee smoking area. Devices are comprised of stainless steel and have a removable stainless steel tub that is able to be cleaned while meeting the requirements of NFPA 101. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The Environmental Services Director or designee will routinely monitor and empty the	

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			receptacles weekly and as needed to prevent accumulation of cigarette butts. Areas will be monitored by the Maintenance Director weekly to audit staff compliance. All staff were educated that cigarette butts are to be place in the newly installed devices. Findings of routine audits will be discussed in QAPI meeting x 3 months or until 100% compliance is achieved for that duration.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observations, records review, and interviews, the facility failed to ensure the annual inspection and testing of 1 of 1 oxygen room fire doors were completed in accordance with LSC 19.1.1.4.1.. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	06/01/2025

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	assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/15/25 at 11:41 a.m., the oxygen transfilling room door was rated as a 45-minute fire door. Based on records review at 10:04 p.m., the documentation of the		Maintenance Director performed door inspection on 5/27/25 and found door to be fully compliant with the 45 minute fire rating. Oxygen room door was added to the annual fire door inspection list in addition to the six other cross-corridor fire doors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Fire Door Inspection reports were added to the QAPI meeting agenda to monitor the inspection of all fire doors on an annual basis.	

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	annual fire door inspections listed six cross-corridor fire door assemblies were inspected, but the oxygen transfilling room fire door was not listed as inspected. Based on an interview at 11:50 a.m., the Maintenance Director stated the oxygen-transfilling room fire door was not inspected. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring and daisy chained together. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 30 residents in the 100-hall. Findings include: Based on observation with the Maintenance Director and Administrator on 05/15/25 at 11:13 a.m., at the 100 hall nurses' station, a power strip was daisy chained together with an extension cord that was powering computer systems. Based on an interview at 11:13 a.m., the Maintenance Director agreed a power strip was plugged into an extension cord.	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The extension cord	06/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 01 B. WING	05/15/2025

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

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	This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m. 3.1-19(b)		noted during survey was removed immediately on 5/15/25. A facility inspection was held on 5/27/25 by the Administrator and Maintenance Director to ensure no additional extension cords were present. Weekly audits will continue x 4 weeks then monthly x 3 months until 100% compliance is achieved. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Maintenance Director will bring inspection reports and discuss findings during daily morning meetings. Additionally, QAPI committee will discuss findings on a monthly basis x 3 months until 100% is achieved for 3 consecutive months.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 20 of 20 full and empty oxygen cylinders were separated and marked to avoid confusion. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Administrator on 05/15/25 at 10:17 a.m., the oxygen storage room contained full and	K 0923	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. **How other residents having the potential to be affected by the**	06/01/2025

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	empty oxygen cylinders, there were signs on the wall indicating which storage rack was for full and empty cylinders, but the full and empty racks both contain a mix of full and empty cylinders. Based on an interview at 10:17 a.m., the Maintenance Director stated the cylinders were mixed and not stored in the proper identified racks. This deficient practice was reviewed with the Maintenance Director and the Administrator during the exit conference at 1:00 p.m.. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Assistant Director of Nursing installed new signage clearly depicting racks for 1) full cylinders and 2) empty cylinders. ADON also notified contracted oxygen company to come to facility and remove any overstock cylinders. Facility has begun transition to portable and refillable oxygen tanks for individual residents on supplemental oxygen. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Maintenance Director or designee will monitor and verify proper oxygen cylinder storage weekly x 4 weeks then monthly x 3 months until three consecutive months of 100% compliance is achieved. QAPI meeting will track and monitor progress with proper storage during that time in monthly QAPI committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 01 B. WING	05/15/2025

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