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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Rehabilitation and Healthcare	1400 Medical Park Dr Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accident prevention interventions were implemented for 1 of 2 residents reviewed for accidents. A resident exited the facility unattended, his whereabouts unknown for approximately 13 hours. He was not noticed to be missing until an hour and half before being found approximately 1 mile away from the facility. (Resident B).Findings include:The Immediate Jeopardy began on 5/19/26 when Resident B was last seen about 1:00 a.m. and reported missing at 2:00 p.m. the next day. He was located at 3:15 p.m., approximately 1 mile from the facility on sidewalk of busy 6 lane highway with a speed limit of 45 mph. He was brought back to the facility where he refused to re-enter the building and was escorted by local law enforcement to the hospital for evaluation. The facility Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on June 11, 2026, at 3:03 P.M. The Immediate Jeopardy was removed, and the deficient practice corrected, on 5/20/26, prior to the start of the survey and was therefore Past Noncompliance.Resident B's record was reviewed on 6/10/26 at 1:20 P.M. Diagnoses included high blood pressure and adjustment disorder (emotional/behavioral reaction to stressful life event).A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident B had moderately impaired cognition. He was independent with activities of daily living (ADL) but refused oral care, toileting hygiene, personal hygiene, and shower/bathing.Care plans indicated the resident was at risk for falls, impaired safety, and injury related to smoking. He had history of behaviors including refusing care, verbal/physical aggression with staff, yelling, cursing, verbal threats, paranoia, auditory hallucinations, agitation, talking to self, anxious complaints, indecisiveness, and racing thoughts. Resident B had current behaviors of urinating/putting feces on bathroom walls, floor and was non-compliant with taking medications. A revised care plan, dated 2/19/26, indicated Resident B had previously been homeless, was appointed a guardian while in the hospital, and needed long-term care. Interventions included to keep the resident safe during episodes of behaviors and attempt to redirect.A physician order, dated 12/16/25, was Resident B may not go on LOA (leave of absence) unless accompanied by a facility staff member for medically necessary appointments. A nurse note, dated 5/19/26, indicated at 2:00 p.m., the Administrator and DON were notified Resident B was unable to be located in the facility. Staff searched the building and grounds around the building but were unable to locate the resident. Staff searched the surrounding areas, and the resident was eventually located at 3:15 p.m., a mile from the facility on the sidewalk next to a busy 6 lane highway with a speed limit of 45 mph. He was brought back to the facility but refused to enter the building. Staff stayed with Resident B outside in the parking lot, talking and trying to coax him to come into the building. Due to continued refusal to return inside and concern for resident's safety, local law enforcement was called. Upon arrival of police, Resident B remained uncooperative and was eventually transported by police vehicle to the hospital for evaluation.Resident B's record had not indicated the resident was not able to be located in the facility.Meal intake records, dated 5/19/26, indicated there was no documentation completed to indicate the resident had eaten breakfast or lunch on 5/19/26.Medication Administration Records (MAR), dated May 2026, indicated Resident B had not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	received his medications as scheduled on 5/19/26 at 8:00 a.m.On 6/10/26 at 4:00 P.M., Qualified Medication Aid (QMA) 2 was interviewed. She indicated she had been the only employee working on the south hall where Resident B resided and had last seen him on 5/19/26 between 12:00 a.m.-1:00 a.m. QMA 2 indicated she hadn't seen him during the remaining hours when she left at 7:00 a.m. She indicated Resident B wandered throughout the facility day and night and the QMA assumed he had been in the building during the night.On 6/11/26 at 10:06 A.M., QMA 6 was interviewed. She worked on the east hall on night shift from 7:30 p.m. on 5/18/26 to 7:00 a.m. 5/19/26 and was the only staff member on the hall. She had not seen Resident B ambulating through the facility during her shift. She indicated Resident B was usually up through the night, would wander around the facility and out to the courtyard during all hours of the night.On 6/11/26 at 10:13 A.M., Registered Nurse (RN) 7 was interviewed. She indicated she was the charge nurse from 7:00 p.m., 5/18/26 until 7:30 a.m. on 5/19/26. She indicated 2 Certified Nurse Aids (CNA) called in on 3rd shift 5/18-5/19/26. She had a QMA and CNA down on her hall and there was 1 QMA on each of the other halls. She had been very busy during the night and hadn't recalled seeing Resident B. She indicated she was unaware no one else had seen the resident. On 6/11/26 at 9:12 A.M., Dietary Aide 10 was interviewed. She indicated on 5/19/26, Resident B's breakfast tray had been returned uneaten.On 6/11/26 at 9:14 A.M., Dietary Aide 11 was interviewed and indicated on 5/19/26, Resident B's lunch tray was sent out but came back uneaten which was unusual as he typically ate 75 % of his meals. She indicated the lunch tray looked like it hadn't been touched or taken off the cart.On 6/11/26 at 12:00 P.M., Licensed Practical Nurse (LPN) 8 was interviewed. She worked 1st shift on the south hall on 5/19/26. She indicated she had just returned from medical leave and was working on an unfamiliar hall. She went to give Resident B his 8:00 a.m. medications and he wasn't in his room. She indicated the resident usually refused his medications, so she hadn't looked for him.Confidential interviews conducted during the survey indicated:-The facility was short-staffed the night Resident B was missing.-The resident usually walked around the facility all day and night drinking coffee and smoking with supervision. He walked around the building and outside in the courtyard without supervision. Resident B always talked to and answered himself. He would speak to people who weren't there.-Staff assumed Resident B was walking throughout the building like per his usual but hadn't had time to look for him.On 6/10/26 at 4:53 P.M., the Administrator and Social Services Designee (SSD) were interviewed. The Administrator indicated she was first notified of the resident's absence at 2:00 p.m. on 5/19/26. The facility elopement plan was put in place and the building and grounds were searched. She then drove around the area in her car and located the resident about a mile away on the sidewalk near a busy 6 lane highway. He returned to the facility with her but hadn't wanted to come back in. When asked, the Administrator indicated through their investigation, they were unable to account for the resident's whereabouts from 1:00 a.m. until 3:00 p.m. on 5/19/26. Resident B told the Administrator, he had moved a table in the courtyard over to the fence and climbed over it. The fence was 6 ft. high. There were cameras in the courtyard, and she reviewed them but was unable to see when the resident had exited the courtyard. The SSD indicated Resident B had been homeless prior to admission to the hospital for a fall with injury. He admitted to the facility after being hospitalized . Resident B's cognition fluctuated, he had daily refusals of care and behavior of talking to himself and others not present. He'd made no attempts previously, to leave the building and had seemed content to walk throughout the facility, drinking coffee, and smoking during scheduled smoke breaks.Current facility policies, titled Emergency Procedure-Missing resident and Routine Resident Checks, were provided on 6/11/26 at 9:20 A.M. which indicated residents at risk for wandering and/or elopement would be monitored and staff would take necessary precautions to ensure their safety. Nursing staff were to make routine resident checks on each unit, at least once per 8-hour shift.The past non-compliance Immediate Jeopardy began on 5/19/26. The Immediate Jeopardy was removed and the deficit practice corrected by 5/20/26 after the facility assessed all residents for elopement risk and exit-seeking behaviors, updated care plans, re-educated all staff on elopement prevention, including (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	routine frequent checks of resident's whereabouts, and removed all moveable furniture in the secured courtyard, and began routine monitoring of each resident's whereabouts in the facility.This Citation relates to Intakes 3019142 and 3020354.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)