

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2013
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NAME OF PROVIDER OR SUPPLIER  PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/20/13</p> <p>Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Parker Health Care &amp; Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>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, in spaces open to the corridors and hard wired smoke detectors in all</p>	K010000	<p>This Plan of Correction is prepared and executed because it is required by the provisions of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of September 19, 2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

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	<p>resident sleeping rooms. The facility has a capacity of 78 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has one detached garage and one barn for facility storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double leaf corridor doors would automatically latch into its door frame. This deficient practice could affect 10 residents observed in the Activities room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/20/13 at 2:00 p.m. with the Maintenance Supervisor, the single set of double leaf corridor doors leading into the Activities room required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. Based on interview on 08/20/13 concurrent with</p>	K010018	<p>1. The set of double leaf coordior doors located at the Activity Room entrance have been equipped with latches that would automatically latch into its door frame. 2. The 10 residents observed in the Activity Room as well as visitors and staff have the potential to be affected. 3. This equipment will be inspected with weekly PM rounds and during fire drills to ensure proper operation. 4. This will be reviewed by the safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Completion Date: September 19, 2013</p>	09/19/2013			

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	<p>the observation, it was acknowledged by the Maintenance Supervisor, the aforementioned corridor doors would not latch independently into the door frame.</p> <p>3.1-19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 46 residents on Center hall as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observations on 08/20/13 during the tour between 1:40 p.m. and 1:50 p.m. with the Maintenance Supervisor, the MDS office had two sprinkler heads on the north part of the ceiling which were measured to be forty one inches apart. Furthermore, the Medical storage room</p>	K010056	<p>1. The sprinkler heads identified in the MDS office and Medical Storage area have been moved and corrected to be at more that 6 feet apart. 2. The 46 residents on Center hall as well as staff and/or visitors have the potential to be affected. 3. All sprinkler heads throughout the facility have been inspected to assure all are spaced more than 6 feet apart. 4. These sprinkler heads will be reviewed by the safety committee and reported to the QA committee for 3 months and annually after that as determined by the QA committee. 5. Compliance Date: September 19, 2013.</p>	09/19/2013			

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	<p>had two sprinkler heads on the east part of the ceiling which were measured to be four and one half feet apart. Based on interview on 08/20/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler heads were less than six feet apart.</p> <p>3.1-19(b)</p>				

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K010070 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review; the facility failed to regulate the use of 1 of 1 portable space heaters in nonresident rooms. This deficient practice could affect anyone visiting the Dietary manager's office on Center hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/20/13 at 2:45 p.m. with the Maintenance Supervisor, a portable space heater which was plugged in for use was located in the Dietary manager's office in the kitchen on center hall. Based on interview on 08/20/13 concurrent with the observation, it was acknowledged by the Maintenance Supervisor, space heaters were allowed in nonresident areas as long as the portable space heater policy was adhered to.</p> <p>Based on review of the portable space heater policy on 08/20/13 at 3:30 p.m. with the Maintenance Supervisor, it stated the facility allowed the use of portable space heaters in nonresident rooms as long as the heating elements did not</p>	K010070	<p>1. The portable space heater that was located in the Dietary Managers office in the kitchen on Center hall has been removed from the facility. 2. Anyone visiting the Dietary Managers office on Center hall as well as visitors and staff have the potential to be affected. 3. All nonresident room areas of the facility have been inspected to assure there are no portable space heaters plugged in without having a specifications sheet for the space heater to show it would not exceed 212 degree F to validate its use. 4. This will be reviewed by the safety committee and reported to QA committee for 3 months and annually as determined by the QA committee. 5. Compliance Date: September 19, 2013</p>	09/19/2013			

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	<p>exceed 212 degrees F. The facility, however was unable to provide a specifications sheet for the space heater in the Dietary manager's office to show it would not exceed 212 degree F to validate its use.</p> <p>3.1-19(b)</p>						