

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 08/14/2014
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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: 08/14/14</p> <p>Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Parker Health Care & 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 fully sprinkled. 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 13, 2014. Parker Health Care respectfully requests paper compliance.</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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K010046 SS=E	<p>resident sleeping rooms. The facility has a capacity of 78 and had a census of 74 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two detached wooden storage buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 exits was provided with emergency powered exterior lighting. This deficient practice affects 28 residents who reside on the East Hall and would use the East Hall exit near the lobby.</p> <p>Findings include:</p>	K010046	<p>1. The East Hall exit near the lobby will be equipped with outside emergency light fixtures outside the exit door or along the ninety six foot long sidewalk surface. 2. The 28 residents that reside on the East Hall and would use the East Hall exit have the potential to be affected. 3. This lighting will be inspected with weekly PM rounds to ensure proper operation. 4. This will be</p>	09/13/2014

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K010070 SS=E	<p>Based on observation on 08/14/14 at 10:20 a.m. with the administrator and maintenance supervisor, the East Hall exit near the lobby had a ninety six foot long sidewalk surface leading to the parking lot. Furthermore, there was no outside light fixtures provided outside the exit door or along the ninety six foot long sidewalk surface. Based on an interview with the maintenance supervisor on 08/14/14 at 10:30 a.m., the East Hall exit near the lobby is not provided with outside emergency lighting. The lack of outside emergency lighting at the East Hall exit near the lobby was verified by the maintenance supervisor and administrator at the time of observation and acknowledged by the administrator at the exit conference on 08/14/14 at 1:50 p.m.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure the use of 2 of 2</p>	K010070	<p>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 13, 2014</p> <p>1. The heating elements in the portable electric space heating devices installed in each</p>	09/13/2014

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	<p>portable space heating devices was prohibited in areas used by residents. This deficient practice affects residents in the facility who use the Front Hall lounge and the fireside lounge.</p> <p>Based on observations on 08/14/14 during a tour of the facility from 9:40 a.m. to 1:45 p.m. with the administrator and maintenance supervisor, the Front Hall resident lounge and the fireside resident lounge each had a fake fire place with a portable electric space heating device installed inside each unit. Furthermore, the portable space heating devices were turned on and were fully functional at the time of observation. The use of space heating devices in the Front Hall resident lounge and the fireside resident lounge was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 08/14/14 at 1:50 p.m.</p> <p>3.1-19(b)</p>		<p>fake fire place in the Front Hall and Fireside Lounge have been removed.2. Anyone visiting in the Front Hall and/or Fireside Lounge areas 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 degrees 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 13, 2014.</p>	