

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/20/2026	
NAME OF PROVIDER OR SUPPLIER PARK PLACE HEALTH AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10820 PARK PLACE, SAINT JOHN, , 46373					
(X4) ID PREFIX TAG K 0000	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG K 0000	PROVIDER'S PLAN OF CORRECTION...		(X5) COMPLETION DATE		
	INITIAL COMMENTS A Life Safety Code State Licensure Survey was conducted by the Indiana Department of Health. Survey Date: 07/20/26 Facility Number: 017974 Provider Number: N/A AIM Number: N/A At this Life Safety Code survey, Park Place Health and Wellness Center was found not in compliance with Requirements of 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. This facility is separated by three distinct buildings identified as Building 1, Building 2, and Building 3. Building 1 (10810 - Faith) is located to the North of the main building. It is a		The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.				

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one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 1 has 13 beds. Building 2 (10820 - Main) is a two-story building and was determined to be of Type II (111) construction and fully sprinklered. Building 2 has 15 beds on the first floor and 15 beds on the second floor. Building 3 (10830 - Hope) is located to the South of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 3 has 13 beds. The facility has smoke detection in corridors and areas open to the corridor. Smoke detectors hard-wired to the fire alarm system are installed in all resident rooms. The hard-wired smoke detectors are connected to the facility's fire alarm system and provide a visual and audible signal at all nurses' station and main foyer entrance; The fire alarm system transmits to a central station service. All three buildings have emergency power supplied by a 250-kW diesel-powered generator. The facility has a total capacity of 56 beds and had a census of 50 at the time of this survey.

Quality Review completed on 07/22/26

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K 0027	LIFE SAFETY CODE STANDARD NFPA 101 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure horizontal exit fire door sets were arranged to automatically close and latch. NFPA 101, 2000 Edition, Section 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. Section 7.2.1.8.2	K 0027	1. Panic bar on fire door near room 115 at rehab 1 building has serviced by local external vendor (TJ Doors) to ensure it properly drops out when power is deactivated. Maintenance Director has been re-educated to ensure that all fire doors are properly functioning and that panic bars are adjusted correctly to ensure that the door drops out properly when power is deactivated. 2. All residents at Rehab 1 building are at risk from this alleged deficient practice. All fire barrier doors at Rehab 1, Rehab 2, Faith, and Hope buildings have been tested to ensure proper functioning, and no further concerns were identified. 3. Maintenance Director/designee will audit all fire barrier doors at Rehab 1, Rehab 2, Faith, and Hope buildings weekly for 3 weeks to ensure proper functioning. 4. Maintenance Director/designee will present fire barrier door audits quarterly for review and discussion by the Interdisciplinary Team through the Quality	08/03/2026
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In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient

Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.

5. Completion date: 8/3/26

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	practice could affect all residents Rehab Building. Findings include: Based on observations conducted with the Maintenance Director on 07/20/26 at 12:05 PM, the rated fire door set consisting of double swing doors located by Room # 115, which serves as a horizontal exit and smoke barrier was equipped with a magnetic door holder and a self closing mechanism, did not close completely when tested multiple times. One door leaf was having an issue with the latching latching mechanism and did not latch completely. During an interview conducted at the time of the observations on 07/20/26 at 12:06 PM, the Maintenance Director acknowledged that the fire rated doors near Room # 115 did not fully close or latch due to a latching mechanism issue. He further stated that the door latching mechanism may require adjustment. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference held on 07/20/26 at 2:00 PM.			
K 0045	LIFE SAFETY CODE STANDARD NFPA 101	K 0045	1. Additional wall sconce light to be added to Rehab 1 exit near room	08/03/2026

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	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the egress lighting for exit means of egress was arranged so the failure of any single lighting fixture would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect all residents, staff, and visitors in the Rehab Building. Findings include: Based on observations made during a facility tour with the Maintenance Director on 07/20/26 at 12:15 PM, the exterior means of egress at the Southeast Exit by Room # 113 was equipped with a single light fixture containing only one (1) LED light. Based on interviews conducted at the time of observation on 07/20/26 at 12:16 PM, the Maintenance Director acknowledged this condition and confirmed that only one (1) LED light source		113 by local external vendor (Hyre Electric). Maintenance Director re-educated to ensure adequate lighting sources are present in/near all exits and that no existing lighting sources are burnt out. 2. All residents at Rehab 1 building are at risk from this alleged deficient practice. All exits at Faith, Hope, and Rehab 1 buildings have been inspected to ensure adequate lighting sources are present in/near all exits and that no existing lighting sources are burnt out; no further issues identified. 3. Maintenance Director/designee will audit all exits from Faith, Hope, and Rehab 1 buildings weekly for 3 months to ensure adequate lighting sources are present in/near all exits and that no existing lighting sources are burnt out. 4. Maintenance Director/designee will present exit lighting audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans	
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	was provided at the exterior exit door of Southeast Exit by Room # 113 and stated that it was undetermined whether the exit path was provided with any additional egress lighting. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference held on 07/20/26 at 2:00 PM. 3.1-19(b)		necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Completion date: 8/3/26	
K 0130	MISCELLANEOUS NFPA 101 OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure receptacle was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet	K 0130	1. Identified electrical outlets at Faith, Hope, therapy department in Rehab 2, and laundry room at Rehab 1 buildings have been replaced with GFCI-equipped outlets by local external vendor (Hyre Electric). Maintenance Director has been re-educated to ensure that electrical outlets near water source are GFCI-equipped outlets. 2. All residents and staff at Faith, Hope, therapy department in Rehab 2, and laundry room in Rehab 1 buildings are at risk from this alleged deficient practice. Maintenance Director has inspected electrical outlets at Faith, Hope,	08/03/2026

location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any resident and staff with access to the therapy room in Rehab Building. Findings include: Based on observation conducted during a facility tour with the Maintenance Director on 07/20/26 at 11:45 AM, one (1) electrical receptacle located in the therapy room, approximately 39 inches from the edge of the sink, was not GFCI-protected. The receptacle was tested using a GFCI tester and failed to trip or interrupt the electrical circuit during testing. Electrical receptacles installed in proximity to water sources are required to be GFCI-protected to reduce the risk of electrical shock. During an interview conducted at the time of the observation on 07/20/26 at 11:46 AM, the Maintenance Director confirmed the condition of the receptacles and stated that the affected outlet would be replaced immediately with GFCI-protected device. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference held on		Rehab 1, and Rehab 2 buildings to ensure they are GFCI-equipped outlets as needed; no further issues identified. 3. Maintenance Director/designee will audit/inspect all electrical outlets that were identified and replaced in Faith, Hope, Rehab 1, and Rehab 2 buildings for proper functioning monthly for 3 months. 4. Maintenance Director/designee will present electrical outlet audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Completion date: 8/3/26	
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	07/20/26 at 2:00 PM. 3.1-19(b)			
K 0144	LIFE SAFETY CODE STANDARD NFPA 101 Generators are inspected weekly and exercised under load for 30 minutes per week in accordance with NFPA 99. 3.4.4.1.	K 0144	1. Battery inspections for the generator are up to date; no further action to be taken regarding existing documentation. Vendor (Alterative Energy Solutions) has been notified that future inspection reports of the generator's maintenance-free batteries will need to state "full charge" rather than "full" to alleviate potential confusion. Maintenance Director has been re-educated on ensuring that generator maintenance-free battery inspection reports indicate "full charge" rather than "full" moving forward. 2. No further residents were at risk due to this alleged deficient practice. No further action to be taken. 3. Maintenance Director/designee will audit/inspect generator maintenance-free battery monthly for 3 months to ensure they indicate "full charge" rather than "full". 4. Maintenance Director/designee will present generator	08/03/2026

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Based on record review, observation, and interview, the facility failed to maintain a complete written record of generator testing and maintenance in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition and NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition. NFPA 99, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Chapter 8. Section 8.3.7.1 states Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.

This deficient practice could affect all occupants.

Findings include:

Based on a records review conducted with the Maintenance Director on 07/20/26 at 11:40 AM, the facility presented vendor's annual generator battery test title "Generator Service Program" dated 03/02/26. However, the vendor's

maintenance-free battery inspection report audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.

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	documentation shows that "Battery Fluid Level: Full". Moreover, no documentation of a monthly battery test for the diesel generator was available for review. During a facility tour on 07/20/26 at 10:20 AM, observations and interviews revealed that the emergency generator batteries were sealed, maintenance-free units that do not require water level. During an interview at the time of the record review on 07/20/26 at 11:41 AM, the Maintenance Director acknowledged the missing battery test and stated that the facility will begin performing the required monthly conductance testing in accordance with code requirements. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference held on 07/20/26 at 2:00 PM. 3.1-19(b)			
K 0154	LIFE SAFETY CODE STANDARD NFPA 101 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is	K 0154	1. Fire watch policy has been updated to include the ISDH incident reporting email, incidents@lsdh.in.gov in addition to listing the ISDH Gateway Portal, to ensure two methods of reporting incidents are listed on the fire watch	08/03/2026

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provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with NFPA 101 Life Safety Code, 2000 Edition. NFPA 101, Section 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.2 Sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director on 07/20/26 at 11:28		policy. Maintenance Director has been re-educated on the need to have two methods of reporting incidents to ISDH. 2. No further residents were at risk due to this alleged deficient practice. Fire watch policy was updated at time of Life Safety Survey exit in the presence of surveyor; no further actions are to be taken. 3. Executive Director/designee will audit Fire Watch policy monthly for three months to ensure all data is up to date, including having 2 methods of reporting any incident to ISDH listed on it. 4. Executive Director/designee will present Fire Watch policy audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Completion date: 8/3/26	
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AM, the facility provided documentation titled "Fire Safety: Fire Watch." Review of this documentation revealed that the required reporting process did not identify the secondary means of reporting. Specifically, the policy included instructions only for notifying the Indiana Department of Health (IDOH) through the primary reporting method via the IDOH Gateway (<https://gateway.isdh.in.gov>) and did not include the secondary reporting method to be used if the IDOH Gateway is nonoperational. The secondary reporting method requires completion of the Incident Reporting form and submission via email to incidents@isdh.in.gov. During the interview at the time of the record review on 07/20/26 at 11:29 AM, the Executive Director acknowledged that the fire watch documentation did not include instructions for reporting to IDOH using also the designated secondary reporting email address if the gateway is nonoperational.

This finding was reviewed with the Executive Director and Maintenance Director during the exit conference held on 07/20/26 at 2:00 PM.

3.1-19(b)

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K 0155	LIFE SAFETY CODE STANDARD NFPA 101 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interviews, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with NFPA 101 Life Safety Code, 2000 Edition. Section 9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. This deficient practice affects all occupants.	K 0155	1. Fire watch policy has been updated to include the ISDH incident reporting email, incidents@isdh.in.gov in addition to listing the ISDH Gateway Portal, to ensure two methods of reporting incidents are listed on the fire watch policy. Maintenance Director has been re-educated on the need to have two methods of reporting incidents to ISDH. 2. No further residents were at risk due to this alleged deficient practice. Fire watch policy was updated at time of Life Safety Survey exit in the presence of surveyor; no further actions are to be taken. 3. Executive Director/designee will audit Fire Watch policy monthly for three months to ensure all data is up to date, including having 2 methods of reporting any incident to ISDH listed on it. 4. Executive Director/designee will present Fire Watch policy audits quarterly for review and discussion by the Interdisciplinary Team through the Quality	08/03/2026
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FORM APPROVED

OMB NO. 0938-0391

Findings include:

Based on record review and interview with the Executive Director on 07/20/26 at 11:28 AM, the facility provided documentation titled "Fire Safety: Fire Watch." Review of this documentation revealed that the required reporting process did not identify the secondary means of reporting. Specifically, the policy included instructions only for notifying the Indiana Department of Health (IDOH) through the primary reporting method via the IDOH Gateway (<https://gateway.isdh.in.gov>) and did not include the secondary reporting method to be used if the IDOH Gateway is nonoperational. The secondary reporting method requires completion of the Incident Reporting form and submission via email to incidents@isdh.in.gov. During the interview at the time of the record review on 07/20/26 at 11:29 AM, the Executive Director acknowledged that the fire watch documentation did not include instructions for reporting to IDOH using also the designated secondary reporting email address if the gateway is nonoperational.

This finding was reviewed with the Executive Director and Maintenance Director during the

Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.

5. Completion date: 8/3/26

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FORM APPROVED

OMB NO. 0938-0391

exit conference held on
07/20/26 at 2:00 PM.

3.1-19(b)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURENathan Wolf

TITLEExecutive Director

(X6) DATE08/14/2026