STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTH AND WELLNESS CENTER	10820 PARK PLACE, SAINT JOHN, , 46373

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00465390. Intake IN00465390 - State deficiency related to the allegations is cited at R9999. Survey date: October 28, 2025 Facility number: 017974 Residential Census: 27 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/31/25.	R 0000	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.	

R 9999	FINAL OBSERVATIONS 410 IAC 16.2-5-1.1 Licenses (e) The director may issue a health facility license for an existing facility that proposes a change in beds upon receipt, review, and approval of the following requirements: (1) The applicant shall submit the appropriate license fee. (2) The facility shall meet the environmental and physical standards of section 1.6 of this rule. (3) The applicant shall submit a report by the state fire marshal that the facility is in reasonable compliance with the fire safety rules of the fire prevention and building safety commission (675 IAC). This requirement was not met as evidenced by: Based on observation and interview, the facility failed to provide the required information and obtain approval from the Indiana Department of Health (IDOH) Division of Long-Term Care prior to changing beds and opening a locked memory care unit. This had the potential to affect 13 residents who resided on the locked memory care unit. Finding includes:	R 9999	**1** **Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** The elevator in AL building has been reprogrammed as of 10/30/25 to always allow operation from second floor down to first floor without needing to use a badge key. Internal reprogramming has been completed as of 11/11/25 to allow the elevator to move freely up from first to second floor from 8am to 7pm daily without using a badge key. **2** **Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents residing on 2nd floor AL have the potential to be affected by the alleged deficient	11/11/2025

	On 10/28/25 at 8:45 a.m., upon entrance to the Assisted Living building, the elevator to the second floor was observed to be locked. There was a sign in front of the elevator that indicated the second floor was a memory care unit and to ask a staff member for assistance to enter the unit. A staff member approached and indicated an employee badge would need to be scanned in order to take the elevator upstairs. On the second floor, a sign was observed in front of the elevator that indicated, "to access elevator, please ask staff member for assistance." During an interview on 10/28/25 at 11:15 a.m., Resident B indicated he was unable to leave the second floor on his own because the elevator was locked. If he wanted to go downstairs or outside, he would have to ask a staff member to go with him. During an interview on 10/28/25 at 2:38 p.m., CNA 1 and CNA 2 indicated residents and visitors were unable to access the elevator without staff assistance. In order to enter or exit the memory care unit, a staff member would have to swipe their badge to open the elevator. During an interview on 10/28/25 at 2:42 p.m., the Administrator		practices. No further actions are taken to identify other residents that have potential to be affected by alleged deficient practice, as it is location-specific to 2nd floor AL only. Administrator, DON, and Maintenance Director have been educated regarding elevator function that is in accordance with 410 IAC 16.2-5-1.1. **3** **The Measures the facility will take to** **ensure the problem will be corrected and will not reoccur:** Administrator or designee will audit elevator functioning 3 times a week for 12 weeks to ensure the elevator operates as described above. **4** **Quality Assurance plans to monitor** **facility performance to make sure corrections are achieved:**	

	and Director of Nursing indicated the second floor was locked memory care unit. Residents and visitors would need staff assistance to enter and exit the unit using the elevator. The stairwell door could be used to exit if it was pushed for 15 seconds, then it would unlock. The elevator had been locked for about 4 months. All the paperwork to open the memory care unit had been submitted but they were unsure if it had been finalized as there was a different Administrator handling things at the time. They were unsure if the memory care unit had been inspected by the state fire marshal or if a plan review had been completed by the IDOH Healthcare Engineering program. No documentation was provided prior to exit indicating an inspection of the unit had been done by the state fire marshall or the plan to lock the unit had been approved by IDOH. This citation relates to Intake IN00465390.		Elevator audit tools will be reviewed and discussed 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 Interdisciplinary Team review.	

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) DATE11/11/2025