STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155489	A. BUILDING 01 B. WING	08/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 08/21/17 Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190 At this Life Safety Code survey, Parker Health Care & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2012 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 one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 89 and had a census of 73 at	K 0000	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 20, 2017. Parker Health Care respectfully requests paper compliance.	

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

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	the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/31/17 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 3 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the following was noted: a. a wheeled weigh scale was stored in	K 0211	1. 20 residents, staff, and visitors have the potential to be affected. Immediate action was taken by relocating the wheeled weigh scale to the central shower room, the couch located in the corridor outside room 105 was removed from that location, and the 2 couches that were stored opposite of one another in the exit lobby by the south nurses station were also removed. 2. Maintenance staff did a walk through of the facility to inspect and assure that no other means of egress was obstructed. 3. To assure this deficient practice does not recur, all means of egress will be inspected weekly	09/20/2017

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	the corridor outside Room 3 and projected three feet into the eight foot wide corridor width. b. a couch was stored in the corridor in the day room by Room 105 which projected sixteen inches into the eight foot wide corridor. c. two couches were stored opposite one another along with a table in the exit lobby by the south nurses station which left a 66 inch wide egress path to the lobby doors in the twelve foot wide lobby. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3.1-19(b)		times 4 weeks, then monthly times 3 months to observe for any possible obstructions. 4. Corrective actions will be monitored with our TELS system as part of our Preventative Maintenance process. Any deficient practice observed will be taken to our QA Committee that meets monthly. 5. Systemic changes to be completed by September 20, 2017	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the			

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	following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			

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	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure restrooms for 42 of 44 resident sleeping rooms were not equipped with locks which cannot be opened from the egress side. LSC Section 7.2.1.5.1 states door leaves shall be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of a key, tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect 71 residents. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, restrooms in 42 of 44 resident rooms were each equipped with a sliding bolt lock on the room side of the	K 0222	1. This deficient practice could affect 71 residents. 2. All residents that have the ability to use the adjoining restroom have the ability to be affected. 3. The Maintenance Supervisor will remove all sliding bolt locks on the room side of the restroom which could not be opened from the inside of the restroom. 4. The Maintenance Supervisor will assure that if a lock is installed on any adjoining resident restroom that a door handle lock is installed that can unlock from the inside of the restroom. 5. Corrective action to be completed by September 20, 2017.	09/20/2017

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	restroom door which could not be opened from inside the restroom. Each restroom was also equipped with a door handle lock which could be unlocked from the inside the restroom. Based on interview at the time of the observations, the Maintenance Director stated 42 of 44 resident rooms share a restroom with an adjoining resident room and the sliding bolt lock was installed on each restroom door to ensure privacy but agreed the restroom doors could not be opened from inside the restroom. 3-1.19(b)			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 7 corridors or met an	K 0232	1. This deficient practice could affect 20 residents, staff, and visitors. Immediate action taken	09/20/2017

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	exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised		to move the couch stored in the corridor in the day room by room 105. The 2 couches stored opposite one another along with the table in the exit lobby were removed from the area. 2. The Maintenance Supervisor will inspect the areas of egress to assure areas are free of obstruction, and if a piece of furniture is in the area that it's attached securely to the wall or the floor. 3. All areas of egress will be inspected weekly times 4 weeks, and then monthly times 3 months by the Maintenance Supervisor to assure no objects of obstruction have been placed in these areas. 4. Any identified issues will be taken directly to the QA Committee for further monitoring, and correction. 5. Completed by September 20, 2017	

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	automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the following was noted: a. a couch was stored in the corridor in the day room by Room 105 which projected sixteen inches into the eight foot wide corridor. The couch was not securely attached to the floor or to the wall. b. two couches were stored opposite one another along with a table in the exit lobby by the south nurses station which left a 66 inch wide egress path to the lobby doors in the twelve foot wide lobby. The couches and the table were not securely attached to the floor or to the wall. Based on interview at the time of the observations, the Maintenance Director stated furniture was stored in the aforementioned means of egress which projected into the corridor and was not affixed to the floor or to the wall. 3.1-19(b)			

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K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 1 vertical openings in accordance with 19.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.7.1.3 requires doors in barriers required to have a fire resistive rating shall have a minimum ¾ hour fire protection rating and be self-closing or automatic closing. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Activities Room.	K 0311	1. This deficient practice has the potential to affect 20 staff, residents, and visitors in the vicinity of the Activity Room. 2. Any other staff member, resident, and/or visitor in the vicinity of the Activity Room have the potential to be affected. The Maintenance Supervisor disconnected the operable ceiling fan, and and sealed closed the unprotected vertical opening so that it can no longer be opened. 3. This ceiling fan, and vertical opening will no longer be operable. 4. Will report to QA Committee that this ceiling fan, and vertical opening will no longer be operable as well as in-servicing all Activity staff members.	09/20/2017

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, a three foot by three foot opening was noted in the Activities Room ceiling which contained an operable electric fan. The opening did not have a door or fire damper or any attached ductwork which exposed the attic above. The fan exhausted Activities Room air directly into the attic. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned fan exhausted Activities Room air directly into the attic and served as an unprotected vertical opening. 3.1-19(b)		5. Completion date: September 20, 2017	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or			

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	field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the laundry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, a one half inch hole was noted in the attic access door in the ceiling of the laundry which did not serve to	K 0321	1. This deficient practice could affect 15 residents, staff, and visitors in the vicinity of the laundry. 2. The Maintenance Supervisor will replace the attic access door as the hole in the previous door did not separate this hazardous area from other spaces by smoke resistant partitions. 3. The Maintenance Supervisor will inspect the other 10 hazardous areas to assure they are separated from other areas by smoke resistant partitions. 4. Any areas of concern will be immediately reported to the QA Committee for further monitoring, and immediate correction. 5. Completion Date: September 20, 2017	09/20/2017

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	separate this area from the attic with smoke resistant partitions. Based on interview at the time of the observations, the Maintenance Director stated he needed to replace the attic access door and agreed the hole in the door did not separate this hazardous area from other spaces by smoke resistant partitions. 3.1-19(b)			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1			

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	through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected in accordance with NFPA 96. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. Section 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning	K 0324	1. This deficient practice of not having proof of the inspection/cleaning on the premises, and not having a grease drip tray beneath the lower edges of the range hood could potentially affect 3 staff members and visitors in the kitchen. 2. Please see the attached invoice indicating the semiannual kitchen exhaust system was inspected and cleaned on 10/4/16 by Preventive Maintenance Service. Our Maintenance staff installed a drain line with an enclosed container for grease to drain into. 3. Our Maintenance Supervisor will continue to assure the semiannual inspections and cleanings take place per schedule, and that when the work is complete a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning is maintained on our premises. Our Maintenance Supervisor will also assure by inspecting the grease drip container routinely as part of the TELS Preventative Maintenance Program that it's emptied regularly. 4. Any deficient practices will be reported directly to our QA Committee for further monitoring and corrections. 5. Completed Date: September 20, 2017	09/20/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect three staff and visitors in the kitchen. Findings include: Based on review of Preventive Maintenance Service LLC "Contractor's Invoice" documentation dated 04/08/17 and 04/10/16 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 08/21/17, documentation of semiannual kitchen exhaust system inspection six months after 04/10/16 was not available for review. Based on interview at the time of record review, the Maintenance Director stated documentation of semiannual kitchen exhaust system inspection six months after 04/10/16 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, no inspection contractor had affixed a sticker to the range hood documenting kitchen exhaust system inspection six months after 04/10/16. 3.1-19(b)			

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	155489	A. BUILDING 01 B. WING	08/21/2017

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	2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect three staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the kitchen range hood system was missing an enclosed metal container for grease to drain into. Based on interview at the time of the observations, the Maintenance Director stated there was no designated location underneath the kitchen range hood system for the drip tray to drain into an enclosed metal container and the kitchen range hood			

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	system was missing an enclosed metal container for grease to drain into. 3.1-19(b)			
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 3 corridors were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke	K 0331	1. This deficient practice could affect 20 residents, staff, and visitors in the vicinity of the south nurses station. 2. Attached you will find the flame spread rating for the carpeting and wood paneling that was not available for review during our Life Safety annual review. 3. Completion Date: September 20, 2017	09/20/2017

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	development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the south nurse's station. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, carpeting and wood paneling was installed on the wall in the corridor across from the south nurse's station.			

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	Based on interview at the time of the observations, the Maintenance Director stated the flame spread rating for the carpeting and wood paneling was not available for review. 3.1-19(b)			
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, smoke detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow	K 0341	1. This deficient practice would affect staff only. 2. The Maintenance Supervisor moved the smoke detector installed on the ceiling in the Housekeeping/Laundry Supervisor's Office to be at least 36 inches from the air supply duct. 3. This deficient practice only affects staff. No corrective action	09/20/2017

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	or closer than 36 inches. This deficient practice would affect staff only. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the Housekeeping/Laundry Supervisor's Office had a smoke detector installed on the ceiling within one inch of an air supply duct. Based on interview at the time of the observations, both the Maintenance Director agreed the aforementioned smoke detector was installed less than 36 inches from an air supply duct. 3.1-19(b)		needed for the residents. 4. The Maintenance Supervisor will assure no other smoke detectors installed on the ceiling in other areas of the facility are at least 36 inches from air supply duct's. If there is a concern it will be directly reported to our QA Committee for further monitoring and correction. 5. Date of completion: September 20, 2017	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services 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. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be	K 0346	1. This deficient practice has the potential to affect all residents, staff, and visitors. 2. The facility Fire Watch Policy/Procedure has now been	09/20/2017

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	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 LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Facility Fire Watch Procedure" with the Maintenance Director from 9:30 a.m. to 12:10 p.m. on 08/21/17, the fire watch plan for fire alarm system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director stated the fire watch documentation stated to contact the Indiana State Department of Health but not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		revised to include contacting the Indiana State Department of Health via the Gateway link at https://gateway.isdh.in.gov as the primary method of contact. Or by the secondary method of contact if the Gateway system is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. 3. Please see the attached revised Fire Watch Policy/Procedure. 4. Staff will be in-serviced on how to go about notifying the ISDH should Fire Watch Procedures be put in place. 5. Date of Completion: September 20,2017	

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K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 73 of 73 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the	K 0354	1. This deficient practice could potentially affect all residents, staff, and visitors. 2. Please see the attached revised Fire Watch Policy to now include how to notify the ISDH in the event our automatic sprinkler system has to be placed out-of-service for more than 10 hours in a 24 hour period. 3. Staff will be in-serviced on the revised contact information that we notify the ISDH through the Gateway link at https://gateway.isdh.in.gov as the primary contact, and or by the secondary contact when the ISDH Gateway is nonoperational by completing the Incident	09/20/2017

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	impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Facility Fire Watch Procedure" with the Maintenance Director from 9:30 a.m. to 12:10 p.m. on 08/21/17, the facility fire watch plan for automatic sprinkler system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director stated the fire watch documentation stated to contact the Indiana State Department of Health but not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		Reporting form and e-mailing it to incidents@isdh.in.gov. 4. Completion Date: September 20, 2017	

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of the fire extinguisher is not more than five feet (60 inches) above the floor. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the kitchenette. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the portable ABC type fire extinguisher located in the kitchenette near the south end of the facility was mounted on the wall with the top of the extinguisher 65 inches above the floor. Based on interview at the time of the observations, the Maintenance Director measured the installation height of the	K 0355	1. This deficient practice has the potential to affect 15 residents, staff and visitors in the vicinity of the kitchenette. 2. The Maintenance Supervisor moved the portable ABC type fire extinguisher located in the kitchenette near the south end of the facility to be no greater than five feet above the floor. 3. The Maintenance Supervisor inspected all other fire extinguisher's to assure others were mounted properly. 4. Date of Completion: September 20, 2017.	09/20/2017

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	portable ABC type fire extinguisher and agreed it was mounted on the wall with the top of the extinguisher greater than five feet above the floor. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is			

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	sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the following was noted: a. the corridor door to the laundry in the 100 Hall was propped in the fully open position with a wedged placed on the floor under the door. b. the cubicle curtain for the resident bed nearest the corridor door to resident Room 17 projected into the doorway and did not allow the door to close and latch into the frame. c. the corridor door to resident Room 23 was stuck to the threshold for the door on the floor and did not allow the door to	K 0363	1. This deficient practice has the potential to affect 20 residents, staff, and visitors. 2. Immediate action taken to remove the wedge placed on the floor under the door to the laundry area on the Assisted Living hall. The cubicle curtain was pulled around to the center of the room away from the corridor in resident room 17 to allow the door to close and latch into the frame. In resident room 23, the threshold for the door on the floor was repaired so this would allow the door to latch into the frame. 3. The Maintenance Supervisor will inspect all doors in the corridor to assure no wedges are placed on the floors keeping doors open. He will also inspect all doors in the corridor to assure no cubicle curtains are projecting into the doorway not allowing the door to close and latch into the frame. He will also inspect all thresholds to assure no more are stuck not allowing corridor doors to latch into the door frame. Inspections will be a part of his routine Preventative Maintenance Program. He will inspect weekly	09/20/2017

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	close and latch into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing and latching and would not resist the passage of smoke. 3.1-19(b)		times 4 weeks, then monthly times 3 months. 4. Areas on concern will be taken directly to the QA Committee for further monitoring and correction. 5. Completion Date: September 20, 2017	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide	K 0372	1. This deficient practice has the potential to affect 15 residents, staff, and visitors in the vicinity of the laundry area.	09/20/2017

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	at least a one half hour fire resistance rating. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the laundry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, a one half inch hole was noted in the attic access door in the ceiling of the laundry which did not maintain the fire resistance rating of the ceiling smoke barrier. Based on interview at the time of the observations, the Maintenance Director stated he needed to replace the attic access door and agreed the hole in the door did not maintain the fire resistance rating of the ceiling smoke barrier. 3.1-19(b)		2. The hole noted in the attic access door in the ceiling of the laundry which did not maintain the fire resistance rating of the ceiling smoke barrier was replaced. 3. The Maintenance Supervisor inspected to assure all other smoke barriers were in good condition maintaining the fire resistance rating. 4. Inspection of the smoke barriers will continue as part of the Preventative Maintenance Program ongoing. Any areas of concern are reported directly to the QA Committee for further monitoring and correction. 5. Completed Date: September 20, 2017	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of			

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PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of corridor doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 20 residents, staff and visitors in the Room 26. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the set of corridor doors by Room 26 each swing in the same direction with the east door equipped with an astragal. The door set was equipped with a door closing coordinator to ensure the door equipped with an	K 0374	1. This deficient practice has the potential to affect 20 residents, staff, and visitors in room 26. 2. The set of corridor doors by room 26 equipped with a door closing coordinator to ensure the door equipped with the astragal closes last forming a smoke resistant barrier was repaired so that the closing coordinator works properly to ensure the door with the astragal closes last and forms a smoke resistant barrier. 3. The Maintenance Supervisor inspected all other sets of corridor doors to assure proper closure, and no gaps. 4. Ongoing inspection of the corridor doors will be part of the TELS Preventative Maintenance Program. Identified concerns will be reported to the QA Committee for immediate repair and further monitoring. 5. Completion Date: September 20, 2017	09/20/2017

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	astragal closes last and forms a smoke resistant barrier but the closing coordinator failed to function properly when test to close five separate times leaving a six inch gap between the doors at the meeting edges. Based on interview at the time of observation, the Maintenance Director stated the aforementioned corridor door closing coordinator was not working properly to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. 3.1-19(b)			
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure 6 of 6 facility service equipment had current inspection certificates to ensure the units were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a	K 0500	1. This deficient practice affects all residents, staff, and visitors. 2. Administrator contacted the facility insurance carrier to obtain the name of an inspector that will come and inspect our boilers and water heaters to have a current Certificate of Inspection documentation. An inspection date has been scheduled. 3. Completion Date: September 20, 2017	09/20/2017

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	fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:30 a.m. to 12:10 p.m. on 08/21/17, Certificate of Inspection documentation from the State of Indiana for the facility boilers identified as IN333068, IN333069 and IN333070 and facility water heaters identified as IN266955, IN287063 and IN332163 had expiration dates of February 2017 or April 2017. Based on interview at the time of record review, the Maintenance Director stated the facility requested a reinspection to renew Certificates as documented on "Request for Reinspection" documentation for the Indiana Department of Fire & Building Services - Boiler and Pressure Vessel Safety dated 03/16/17 but has not had a reinspection or renewed Certificates as of the date of this survey. Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the aforementioned facility boilers and water heaters did not have current Certificate of Inspection documentation from the State of Indiana posted at unit's locations.			

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	3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure working space was maintained for 2 of 2 electrical panels in the maintenance office. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require	K 0911	1. The deficient practice has the potential to affect 10 residents, staff, and visitors in the vicinity of the maintenance office. 2. The Maintenance Supervisor disposed of the wooden cabinet that was mounted to the wall behind the corridor six inches from the electrical panel. The Maintenance Supervisor also moved the trash can that was stored underneath the electrical panel. The Maintenance Supervisor then removed the 2 drawer filing cabinet and fan that was stored underneath a second electrical panel in the room to assure items were not being stored in the working space for the electrical panels in the	09/20/2017

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	examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the work space shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the maintenance office. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, a wooden cabinet was mounted on the wall behind the corridor door to the maintenance office six inches from an		maintenance office. 3. Completion Date: September 20, 2017	

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	electrical panel. A trash can was also stored underneath the electrical panel. In addition, a two drawer file cabinet and a fan were stored underneath a second electrical panel in the room. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned items were installed or were stored in the working space for the electrical panels in the maintenance office. 3.1-19(b)			
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 4 months of the most recent 12 month period. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010 Edition, Section 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. (2) Under operating temperature	K 0918	1. This deficient practice could affect all residents, staff, and visitors in the facility. 2. Attached you will find a load bank test performed on our emergency generator by SafeCare Services on September 12, 2017. 3. The Maintenance Supervisor will assure that annually there is a load bank test performed on our emergency generator. SafeCare has also shared with the Maintenance Supervisor the accurate way to calculate the load % calculation. 4. Completion Date: September 20, 2017	09/20/2017

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	conditions and at not less than 30% of the Emergency Power Supply (EPS) nameplate kW rating. Section 8.4.2.3 requires diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook "Emergency Generator Load Test" documentation with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 08/21/17, emergency generator load testing documentation for monthly load tests conducted on 05/18/17, 06/20/17,			

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	07/24/17 and 08/21/17 did not include the facility's correct emergency generator kilowatt rating in the determination of the load % achieved under operating conditions or include the exhaust gas temperatures under operating conditions as recommended by the manufacturer. The load % achieved for each of the aforementioned monthly load tests was documented as, respectively, 22.7%, 21.7%, 22.8% and 21.7%. Based on interview during the time of record review, the Maintenance Director stated he calculates the load % achieved for monthly load tests and uses 50 kW as the emergency generator rating in the calculation. In addition, the Maintenance Director stated the facility does not conduct annual load bank testing for the emergency generator and does not include the exhaust gas temperatures achieved under operating conditions as recommended by the manufacturer for monthly load tests conducted. Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the nameplate rating listed by the manufacturer on the diesel fired emergency generator stated the emergency generator was rated as 20 kW. Based on interview at the time of the observations, the Maintenance Director stated the facility has not changed or			

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	replaced the facility's emergency generator within the last twelve months and he had been using 50 kW as the nameplate rating in the load % calculation and should have been using 20 kW in the load % calculation. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used			

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	temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 4 of 4 extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient	K 0920	1. This deficient practice could affect over 20 residents, staff, and visitors. 2. The air mattress that was plugged into a power strip was removed and plugged directly into the wall receptical. The refriderator in the MDS Office near Room 22 was removed from the power strip, moved, and plugged into a wall receptical of its own. The operable window air conditioner in the MDS office that was plugged into a multiplug adaptor is now plugged directly into a wall receptical after a new receptical was installed. The juice machine in the kitchen that was plugged into an extension cord is now plugged into an outlet of its own after new electrical line and outlet was installed. 3. The Maintenance Supervisor inspects the facility routinely as part of the TELS system and Preventative Maintenance Program to assure fixed wiring is being used in the patient care vicinity. 4. Any area of concern will be taken to the QA Committee immediately and further monitoring and correction will be put in place immediately. 5. Completion Date: September 20, 2017	09/20/2017

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	during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, the following was noted: a. an air mattress was plugged into was plugged into a power strip underneath the head of the resident bed nearest the corridor door to Room 19. The UL listing of the power strip could not be determined. b. a refrigerator was plugged into a power strip in the MDS Office near Room 22. In addition, an operable window mounted air conditioner was plugged into a multiplug adaptor in the room. c. the juice machine in the kitchen was plugged into an extension cord. two feet from the resident bed nearest the corridor door in Room 101. Based on interview at the time of the observations, the Maintenance Director			

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	agreed power strips, multiplug adaptors and an extension cord were being used as a substitute for fixed wiring and in the patient care vicinity at the aforementioned locations. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are			

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PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

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	not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 7 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage and transfilling rooms inside the facility. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect 10, residents, staff and visitors in the vicinity of the oxygen	K 0923	1. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the oxygen storage and transfilling by the south nurse's station. 2. The 'E' type cylinder that was freestanding on floor inside the oxygen storage room not supported in a proper cylinder stand was removed. 3. The Maintenance Supervisor will inspect this area as part of his Preventative Maintenance Program to assure that we do not have any 'E' tanks in this oxygen storage room that are not supported in a proper cylinder stand. 4. Completion Date: September 20,2017	09/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155489	A. BUILDING 01 B. WING	08/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	storage and transfilling by the south nurse's station. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:20 p.m. on 08/21/17, one 'E' type oxygen cylinder was freestanding on floor inside the oxygen storage and transfilling room near the south nurse's station and was not supported in a proper cylinder stand or otherwise secured from falling. Ten liquid oxygen containers and a total of seven 'E' type cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned 'E' type oxygen cylinder was not supported in a cylinder stand or or otherwise secured from falling. 3.1-19(b)			