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	07/21/2016

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

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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: 07/21/16 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 in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 89 and had a census of 69 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 August 20, 2016. Parker Health Care would also like to respectfully request 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 sprinkled. All areas providing facility services were sprinkled except two detached wooden storage buildings. Quality Review completed on 07/22/16 - DA			
K 0021 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 2 kitchenette doors were held open only by a device	K 0021	1. The 1 of 2 south kitchenette doors that were held open only by a device that would not allow it to close automatically upon	08/20/2016

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	which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 20 residents in the south dining room. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and Housekeeping Supervisor on 07/21/16 at 12:00 p.m., the door leading into the kitchenette from the south dining room was held open with a door wedge. The kitchenette contained a fuel fired water heater making it a hazardous area. Based on interview, this was acknowledged by the Maintenance Supervisor and Housekeeping Supervisor at the time of observation. 3.1-19(b)		activation of the fire alarm system has been corrected by installation of a magnetic lock that is attached to our fire door system. 2. 20 residents in the south dining room have the potential to be affected. 3. All doors in areas that are considered hazardous will be inspected weekly with PM rounds to ensure proper function. 4. This will be reviewed by the safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Compliance Date: August 20, 2016.	

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K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the laundry room, a hazardous area, was provided with self-closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 25 residents in 1 of 6 smoke compartments. Findings include: Based on an observation during a tour of the facility with the Housekeeping Supervisor on 07/21/16 at 11:20 a.m., the soiled side laundry room door did self-close but failed to latch into the frame due to the door rubbing on the frame. The laundry room contain a fuel fired dryer. Based on interview, this was acknowledged by the Housekeeping	K 0029	1. The 1 of 2 corridor doors to the laundry room that did not have a self-closing device has been corrected by installation of a striker plate and adjustment of door closure to assure the door automatically closes and latches into the door frame. 2. 25 residents have the potential to be affected in 1 of 6 smoke compartments. 3. All corridor doors will be inspected with weekly PM rounds to ensure proper function. 4. This will then be reviewed by the safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Date of compliance: August 20, 2016.	08/20/2016

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	Supervisor at the time of observation. 3.1-19(b)			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 3 kitchen doors were provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent slide bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect 25 residents in the main dining room and staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Director of Nursing on 07/21/16 at 11:15 a.m., the kitchen door leading to the main dining room was	K 0038	1. The 1 of 3 kitchen doors leading to the main dining room that was equipped with an independent slide bolt has been corrected as the slide bolt lock was removed completely. 2. 25 residents in the main dining room and staff in the kitchen have the potential to be affected. 3. All door locks in the kitchen area will be inspected with weekly PM rounds to ensure they are correct and that a single action will unlatch the door. This will be reviewed by the safety committee in monthly meeting. The committee will report to the QA committee monthly for the next 2 months, and annually after that as determined by the QA committee. 5. Date of compliance: August 20, 2016.	08/20/2016

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	equipped with an independent slide bolt in addition to the door knob. Based on interview at the time of observation, the Director of Nursing acknowledged the kitchen door to the main dining room had an independent slide bolt. 3.1-19(b)			
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 30 residents in 2 of 6 smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and the Housekeeping Supervisor on	K 0044	1. The 1 of 2 fire door sets that was not arranged to automatically close and latch has been corrected by making proper adjustment on the door jam latch. This gives the reset on the door the ability to reset itself. 2. 30 residents in 2 of 6 smoke compartments have the ability to be affected. 3. Inspection of our fire doors will be added to the weekly PM rounds to ensure they are functioning properly. 4. The findings will be reviewed by the safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Date of Compliance: August 20, 2016.	08/20/2016

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	07/21/16 at 11:35 a.m., the fire door set by room 44 failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed these were fire doors by the Maintenance Supervisor and the Housekeeping Supervisor. 3.1-19(b)			
K 0068 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room and could affect 25 residents in the same smoke compartment. Findings include:	K 0068	1. Supplies have been ordered to install a louvered ventilation duct that passes through the exterior wall in the laundry room behind the dryer. Since being hooked up to the controls of the dryer this will ensure the louvers open every time the dryer kicks on providing fresh air intake. Attached you will find the work order for installation and the supply order. 2. This could create an atmosphere of carbon monoxide which could cause physical problems for staff in the laundry room and could affect 25 residents in the same smoke compartment. 3. After this system has been installed, the Maintenance Supervisor will add	08/20/2016

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	Based on observation during a tour of the facility with the Housekeeping Supervisor on 07/21/16 at 11:29 a.m., the laundry room had a fuel fired dryer with no fresh air intake. Based on interview, this was acknowledged by the Housekeeping Supervisor at the time of observation. During exit conference with the Maintenance Supervisor at 1:30 p.m., it was stated that the window in the laundry room was to act as a fresh air intake but during observation the window was closed when the dryer was in operation. 3.1-19(b)		this to his weekly PM inspections to ensure proper functioning of this system. 4. This will then be reviewed by safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Date of Compliance: August 20, 2016.	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as extension cord power strips were not used as a substitute for fixed wiring and 1 of 1 flexible cords such as extension cord power strips to provide power equipment with a high current draw. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, and 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be	K 0147	1. 2 of 2 flexible cords, extension power cord strips observed, were removed immediately from the Social Service office. The Maintenance Supervisor ran new electrical line to connect to four new receptacle's on its own circuit. 2. This had the potential to affect 10 residents in 1 of 6 smoke compartments. 3. The Maintenance Supervisor will add to PM rounds inspection weekly of flexible cords and cables to ensure they are not being used as a substitute for fixed wiring of a structure. 4. This will be	08/20/2016

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	used as a substitute for fixed wiring of a structure. This deficient practice could affect 10 residents in 1 of 6 smoke compartments. Findings include: Based on an observation during a tour of the facility with the Maintenance Supervisor and Housekeeping Supervisor on 07/21/16 at 11:45 a.m., an extension cord power strip was plugged in and providing power to another extension cord power strip which powered computer equipment in Social Service office. Also, a refrigerator and microwave was plugged into an extension cord power strip in Social Service office. Based on interview at the time of observation, the Maintenance and Housekeeping Supervisor acknowledged the power strips. 3.1-19(b)		reviewed by the safety committee in monthly meeting. The committee will report to QA committee monthly for the next 3 months, and annually after that as determined by the QA committee. 5. Date of Compliance: August 20, 2016.	