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	07/08/2015

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: 07/08/15 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 78 and had a census of 70 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 7, 2015.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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.			
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 the corridor door to 3 of 6 hazardous areas, such as fuel-fired heater rooms and soiled storage rooms were self closing and latch into the door frame. This deficient practice could affect 52 residents throughout the facility Findings include: Based on an observation during a tour of the facility with the Maintenance Supervisor on 07/08/15 from 10:06 a.m.	K 0029	1. The 3 of 6 corridor doors to hazardous areas that were equipped with a self closing device but did not latch into the frame have been repaired so that the corridor doors now latch into the frames properly. 2. 52 residents have the potential to be affected. 3. All 6 corridor doors will be inspected with weekly 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	08/07/2015

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	to 12:00 p.m., the following corridor doors to hazardous areas were equipped with a self closing device but did not latch into the frame: a) the sprinkler riser room which contained a gas water heater. b) the shower room by room 49 which contained soiled linen and trash storage. c) the shower room by room Director of Nursing office which contained soiled linen and trash storage. Base on interview, this was confirmed by the Maintenance Supervisor at the time of observations. 3.1-19(b)		by the QA committee. 5. Completion Date: August 7, 2015.	
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,	K 0038	1. The independent sliding bolt lock in 1 of 3 kitchen doors was removed. 2. 45 residents in the dining room and kitchen staff have the potential to be affected. 3. All 3 kitchen doors were inspected to assure proper locking devices are in place. 4. These kitchen doors and locks will be reviewed by the safety committee and reported to the QA committee for 3 months and annually after that as determined by the QA committee. 5. Compliance Date: August 7,	08/07/2015

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	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 45 residents in the dining room and staff in the kitchen. Findings include: Based on observation with during a tour of the facility with the Maintenance Supervisor on 07/08/15 at 11:30 a.m., the kitchen door leading to the dining room was equipped with an independent slide bolt in addition to the door knob. Based on interview, the Maintenance Supervisor acknowledged the kitchen door to the dining room had an independent slide bolt at the time of observation. 3.1-19(b)		2015	
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance	K 0062	1. There was not been an internal pipe inspection completed since 2009 due to a full sprinkler system flush completed on 8/1/2012. Our maintenance supervisor is fairly new to the facility and his position as he was	08/07/2015

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	of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Supervisor on 07/08/15 at 09:35 a.m., the VFP Fire Systems form titled "Report of Inspection and Testing" indicated an internal inspection of the pipes had been completed on 08/17/2009. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to show an internal pipe inspection was completed in the last five years. 3.1-19(b)		not aware that once a sprinkler system is completely flushed an internal pipe inspection doesn't need to be completed until 5 years following the flush. See attached document regarding sprinkler system flush. 2. All residents have the potential to be affected. 3. This equipment will be inspected per requirements every 5 years. 4. The maintenance supervisor will ensure inspections are completed timely and in proper operation. This will be reviewed by the safety committee in monthly meeting. The committee will report to QA committee for the next 3 months, and annually after that as determined by the QA committee. 5. Completion Date: August 7, 2015.	
K 0147 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition.	K 0147	1. The regular light weight extension cord observed in the Activity Directors office was unplugged and removed from the office. 2. The 5 residents close to the Activity Directors office have the potential to be affected. 3. Maintenance Supervisor inspected all offices to ensure no	08/07/2015

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	NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 5 resident near the Activity Director's office. Findings include: Based on an observation during a tour of the facility with the Maintenance Supervisor on 07/08/15 at 10:05 a.m., a regular light weight extension cord was plugged in and providing power for computer equipment in the Activity Director's office. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)		other extension cords were being used as a substitute for fixed wiring. These offices will by inspected with weekly PM rounds. 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. Completion Date: August 7, 2015.	