STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155378	A. BUILDING -- B. WING	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/07/25 Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270 At this Emergency Preparedness survey, Signature Healthcare at Parkwood was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 106 certified beds. At the time of the survey, the census was 84. Quality Review completed on 03/10/25	E 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility requests desk review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/07/25 Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270 At this Life Safety Code survey, Signature	K 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility requests desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Lazar	Administrator	03/13/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Healthcare at Parkwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors hard wired smoke detectors in ten resident rooms on Maplewood Hall and battery powered smoke detectors in all other resident sleeping rooms. The facility has a capacity of 106 and had a census of 84 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/10/25			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer	K 0324	**Deficiency ID: K324** **Cooking Facilities** Completion Date: 3/10/2025 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a The Maintenance Director placed tape on the floor under the legs of six burner stove and the	03/10/2025

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	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 18 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Director of Plant Operations on 03/07/25 at 1:45 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview at the time of the observation, the Director of Plant Operations stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was discussed with the Director of Plant Operations and the facility Administrator at the exit conference on 03/07/25 at 2:11 p.m.		flat grill to mark approved placement, and to ensure that the appliances are returned to the approved design location after cleaning and/or maintenance. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents, visitors, and staff in the main dining room and kitchen have the potential to be affected by alleged deficient practice. b This is the facility's only cooking facility. No other audits are required. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing compliance all Maintenance Director and all dietary staff were educated on approved placement of 6 burner stove and flat grill and the use of the tape on the floor to mark and ensure that appliances are returned to the approve design location after cleaning and/or maintenance. b Maintenance Director and/or designee will audit Cooking Facilities 3 times weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure appliances are returned to approve design	

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	3.1-19(b)		location as noted by tape on the floor. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator and/or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made during a tour of the facility with the Director of Plant Operations on 03/07/25 at 1:40 p.m., the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 01/01/2008 at 11:10 a.m. on 03/07/25	K 0345	**Deficiency ID: K 345 Fire Alarm System-Testing and Maintenance** Completion Date: 3/10/2025 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a The Fire Alarm System was updated with the accurate time and date information in accordance with the requirement. 2 How other residents having the potential to be affected by the same deficient practices will be	03/10/2025

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	at 1:40 p.m. Based on interview at the time of observation, the Director of Plant Operations indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel as soon as possible. This item was discussed with the Director of Plant Operations and the facility Administrator at the exit conference on 03/07/25 at 2:11 p.m. 3.1-19(b)		identified and what corrective action will be taken: a All residents, visitors, and staff have the potential to be affected by alleged deficient practice. b Fire Alarm System was update with accurate time and date information in accordance with the requirement. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing compliance, the Maintenance Director was educated on the Fire Alarm System requirement to accurate time and date. b Maintenance Director and/or designee will audit the Fire Alarm System 3 times weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure accurate date and time on Fire Alarm System. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator and/or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI	

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			committee has the right to modify or extend monitoring times according to the outcomes of audits.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the	K 0761	**Deficiency ID: K 761 Maintenance, Inspection & Testing-Doors** Completion Date: 3/10/2025 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a The Oxygen Storage and Transfilling Room door was inspected by the Maintenance Director and added to the Annual Fire Door Assembly Inspection Document in Tels. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents, visitors, and staff have the potential to be affected by alleged deficient practice. b A facility wide audit completed to ensure all Fire Doors had received annual inspection and testing. 3 What measures will be put into place and what systemic	03/10/2025

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	following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant Operations (D.P.O.) on 03/07/25 at 12:18 p.m., the oxygen storage and transfilling room was not documented as being inspected in the annual fire door assembly inspection documents dated 01/12/25. Based on observation during a tour of the facility, the oxygen storage and transfilling room was located in the main hall. Based on interview at the time of records review, the D.P.O.		changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing compliance, the Maintenance Director was re-educated on the requirement that all fire door assemblies be inspected and tested not less than annually including a written record of the inspection signed. b CEO and/or designee will audit the Oxygen Storage and Transfilling Room door is added to the Facility's Annual Fire Door Assembly Inspection Document monthly times 3 months, then quarterly for 3 quarters to ensure Oxygen Storage and Transfilling Room door is on the Annual Fire Door Assembly Inspection Document. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator and/or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	

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	stated he must have forgotten to add that door to his list to inspect and inadvertently forgot to inspect it this year adding that he would inspect the door and all it's items as soon as possible. This item was discussed with the Director of Plant Operations and the facility Administrator at the exit conference on 03/07/25 at 2:11 p.m. 3.1-19(b)			