STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155348	A. BUILDING -- B. WING	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW CARE CENTER	2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720

(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: 07/12/23 Facility Number: 000239 Provider Number: 155348 AIM Number: 100290150 At this Emergency Preparedness survey, Parkview Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 108 certified beds. At the time of the survey, the census was 64. Quality Review completed on 07/18/23	E 0000		
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: 07/12/23 Facility Number: 000239 Provider Number: 155348 AIM Number: 100290150 At this Life Safety Code survey, Parkview Care Center was found not in compliance with	K 0000	July 31, 2023 Brenda Buroker Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Parkview Care Center	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Adams	Executive Director	07/31/2023

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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	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 108 and had a census of 64 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached garage used for maintenance and facility storage. Quality Review completed on 07/18/23		Life Safety Survey ID 2XGX21 Dear Ms. Buroker; On July 12, 2023 a Life Safety Survey was conducted at our facility. By submitting the enclosed material, Parkview Care Center nor its management company are not admitting the truth or accuracy of any specific findings or allegations. Parkview Care Center reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective August 12, 2023 to the State findings of the Life Safety Survey conducted on July 12, 2023. Parkview Care Center respectfully requests a desk review. Please feel free to contact the facility if any additional information is needed. Respectfully submitted, Krista Adams, B.S.N., R.N. HFA Executive Director	

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			Parkview Care Center	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 34 of the past 52 weeks for the sprinkler system's pressure gauges, and during 8 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13.	K 0353	This Plan of Correction is to serve as Parkview Care Center's credible allegation of compliance. By submitting the enclosed materials, Parkview Care Center nor it's management company are not admitting the truth or accuracy of any specific findings or allegations. Parkview Care Center reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of	08/12/2023

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	Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 07/12/23 between 9:45 a.m. and 1:30 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 34 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 34 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility on 05/11/23 between 1:30 p.m. and 3:30 p.m. the facility had three pressure gauges at the sprinkler riser. b. Based on record review on 07/12/23 between 9:45 a.m. and 1:30 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 8 of the past 12 months. Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit		compliance effective August 12, 2023 to the state findings of the Life Safety Code Recertification and State Licensure conducted on July 12, 2023. Parkview Care Center respectfully requests a desk review. K-353 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the dry sprinkler system's pressure gauges and control valves were inspected and documented. Tri-state fire replaced the 3 sprinkler heads noted within the survey. No resident experienced a negative outcome due to overlooked inspections. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this alleged deficient practice. The Maintenance Director was educated on NFPA 25 Section 5.1.2 and Section 4.3.1, the standard for the inspection, testing and maintaining of water-based fire protection systems and ensuring the sprinkler system gauges and control valves are inspected weekly and documented. The Maintenance Director was also educated on NFPA 25, 5.2.1.1.1 which states sprinklers shall be free of corrosion. Tri-state fire	

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	conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 7 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff plus all resident while in the adjoining dining room. Findings include: Based on observations on 07/12/23 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director, there were three sprinkler heads in the kitchen covered with green corrosion. Based on interview at the time of observation, the Maintenance Director and Executive Director agreed three sprinkler heads in the kitchen were covered with green corrosion and should be replaced. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		completed a visual audit of all sprinkler heads within the facility for corrosion and replaced those found to be deficient. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* the weekly inspection schedule for the dry sprinkler system's pressure gauges and control valves was placed into the TELs system for the Maintenance Director to complete timely. An inspection tool was created for the Maintenance Director to complete visual inspection of all sprinkler heads within the facility monthly for any corrosion, foreign material, pain or physical damage. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the TELs maintenance schedule for dry sprinkler system's pressure gauges and control valves and the visual inspection tool will be monitored weekly for 4 weeks, monthly for 5 months then quarterly for 2 quarters by the Executive Director. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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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 6 smoke barrier walls was protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect at least 30 or more residents, as well as staff and visitors. Findings include: Based on observations on 07/12/23 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director and Executive Director, the smoke barrier wall above the smoke barrier doors between the 100 and 200 halls had three, one to three inch holes penetrating the wall with wire bundles and sprinkler pipes running through it that were not proper fire stopped. Based on interview at the time of observation, the Maintenance Director said the openings through the smoke barrier wall would be filled with a	K 0372	K-372 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* Maintenance Director filled the holes which penetrated the smoke barrier wall with proper fire stop material. No resident experienced a negative outcome due to holes in the smoke barrier wall. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. The Maintenance Director completed a visual audit of all smoke barrier walls to ensure there were no other holes and completed any required maintenance of any deficiencies.	08/12/2023

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	proper fire stop material as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		*3.) The measures that have been put into place to ensure that the deficient practice does not recur is* the Maintenance Director was educated on LSC 19.3.7.5 requiring smoke barriers are to be constructed in accordance with LSC 8.5 and shall have a minimum ½ hour fire resistive rating. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented for visual audits of all smoke barrier walls monthly for 6 months. The results of these audits will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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 observation and interview, the facility	K 0500	K-500	08/12/2023

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	failed to ensure 6 of 6 fuel-fired water heaters had current inspection certificates to ensure the water heaters 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 fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 07/12/23 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director and Executive Director, all six fuel-fired water heaters in the facility had inspection stickers with expiration dates of 06/03/23. Based on interview at the time of each observation, the Maintenance Director and Executive Director confirmed the expiration dates of the six fuel-fired water heaters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		*1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the Maintenance Director contacted the boiler inspection company who completed the inspection August 2, 2023. No resident experienced a negative outcome due to the late inspection. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. Maintenance Director was educated on NFPA 101, Section 19.1.1.3.1 requiring all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency including inspections of water heaters every 2 years *3.) The measures that have been put into place to ensure that the deficient practice does not recur is that* a the Maintenance Director has placed a call with the TELs representative to put a reminder in the TELs scheduled maintenance for 6 months before the next water heater inspection is due. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is* a Quality Assurance tool has been designed and implemented for the Maintenance Director to complete	

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			visual inspection of water heater inspection tags monthly for 6 months then quarterly for 2 quarters. The results of these audits will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 07/12/23 between 9:45 a.m. and 1:30 p.m. with	K 0712	K-712 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a fire drill was completed for 1st shift in 3rd quarter of 2023. No resident experienced a negative outcome due to missed fire drills. *2.) The corrective action taken for the other residents that have the*	08/12/2023

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	the Maintenance Director present, the facility lacked fire drill documentation for the first shift (day) of the second quarter (April, May, and June) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed the lack of a fire drill report during the first shift of the second quarter. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 3 of 11 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 07/12/23 between 9:45 a.m. and 1:30 p.m. with the Maintenance Director present, 1 of 11 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. These drills were dated 08/30/22, 09/27/22, and 03/28/23. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information on the three fire drill reports to verify that transmission of the alarm was received by the monitoring company.		*potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. The Maintenance Director was educated on LSC 19.7.1.4 requiring fire drills to be completed every shift every quarter. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a fire drill calendar was created to ensure a fire drill every month on three different shifts every quarter maintaining a 2 hour gap between fire drills is scheduled. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been designed and implemented for the Executive Director to review fire drill documentation monthly for 6 months then quarterly for 2 quarters. The results of these audits will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3-1.19(b) 3. Based on record review and interview, the facility failed to provide complete fire drill documentation for 4 of 11 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 07/12/23 between 9:45 a.m. and 1:30 p.m. with the Maintenance Director present, fire drill reports dated 10/25/22 and 05/25/23 did not include the names and signatures of staff that participated in the fire drills, furthermore, fire drill reports dated 08/30/22 and 09/27/22 did not include information about the drill, only a date and time with staff signatures were included on the fire drill reports. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures and fire drill information on the previously mentioned fire drill reports. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 4. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.			

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	Findings include: Based on review of the facility's fire drill reports on 07/12/23 between 9:45 a.m. and 1:30 p.m. with the Maintenance Director present, the following was noted: a. 3 of 4 second shift (evening) fire drills were performed between 6:00 p.m. and 6:33 p.m. b. 3 of 4 third shift (night) fire drills were performed between 4:55 a.m. and 5:30 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times the second and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			