STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155328	A. BUILDING -- B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK TERRACE VILLAGE	25 S BOEHNE CAMP RD EVANSVILLE, IN 47712

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/04/22 Facility Number: 000221 Provider Number: 155328 AIM Number: 100267620 At this Emergency Preparedness survey, Park Terrace Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 96 certified beds, with a current census of 61. Quality Review completed on 10/11/22	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: 10/04/22 Facility Number: 000221 Provider Number: 155328 AIM Number: 100267620 At this Life Safety Code survey, Park Terrace Village was found not in compliance with	K 0000	Plan of Correction for Park Terrace Village K0000 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve 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 that the plan of	

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

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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 and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 61 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/11/22		correction be considered our allegation of compliance effective October 23rd, 2022. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 23, 2022.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 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 or 19.3.5.9. 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 field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation 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 K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as a storage room door, was provided with a self closing device. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 10/04/22 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the Activity storage room in the front entrance corridor was full of cardboard boxes, plastic totes, plus paper and plastic items. The corridor door to this room was not provided with a self closing device. This room was over 50 square feet in size. Based on interview at the time of observation, the Maintenance Supervisor agreed the corridor door to this Activity storage room was not provided with a self-closing device. This finding was reviewed with the Executive	K 0321	**K-0321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Maintenance Supervisor to be educated on the importance of hazardous areas -enclosures/ self-closing device. · A self-closure device was installed on 10/19/22 on the Activities storage room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents under the care of the facility have the potential to be affected by the alleged deficient practices · A 100% audit of all	10/23/2022

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	Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		hazardous area doors for self-closure door and functioning will be completed to ensure compliance. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director/designee will ensure that hazardous areas doors are self-closing devices and kept in working condition. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance director/ designee will complete a hazardous area self-closure device audit tool weekly to ensure that the self -closure devices are in place and functioning times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee. Date of compliance 10/23/22.	

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