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	10/09/2024

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: 10/09/24 Facility Number: 000239 Provider Number: 155348 AIM Number: 100290150 At this Emergency Preparedness survey, Parkview Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 99 certified beds. At the time of the survey, the census was 81. Quality Review completed on 10/15/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	October 27, 2024 Brenda Buroker Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Parkview Care Center Life Safety Survey ID 4N0S21 Dear Ms. Buroker; On October 9, 2024 a Life Safety Code Recertification and Emergency Preparedness 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Adams	Executive Director	10/27/2024

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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			requests the plan of correction be considered our allegation of compliance effective October 27, 2024 to the State findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on October 9, 2024. 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 Parkview Care Center	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 2 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly	E 0041	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	10/27/2024

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	testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no monthly generator load test documentation available for August and September of 2024 for the emergency generator. Based on interview at the time of record review, the Executive Director confirmed there was no monthly load test documentation available for August and September of 2024.		responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective October 27, 2024 to the state findings of the Life Safety Code Recertification and State Licensure conducted on October 9, 2024. Parkview Care Center respectfully requests a desk review. E-041 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the facility completed generator load testing and inspection/testing of the generator serving the emergency electrical system of the facility on October 25, 2024. No resident experienced a negative outcome due to missed written record of monthly testing. *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 2012 NFPA 99 Chapter 6.4.4.1.1.4(a), NFPA 110, the Standard for Emergency and Standby Powers System, Chapter 8., Chapter 6-4.4.1.3 of 2012 NFPA 99, NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems 8.3.7 and 8.3.7.2, and	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 5 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly between August 23 and October 4, 2024. Based on interview at the time of record review, the Executive Director confirmed there was no weekly generator inspection/testing documentation available for review between		Chapter 6.5.4.2 of NFPA. The Maintenance Director completed a generator load test and inspection/testing of the emergency generator. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* the monthly inspection schedule for the load bank testing of the generator and the weekly inspection/testing for the generator was placed into the TELs system for the Maintenance Director to complete timely. An inspection tool was created for the Maintenance Director to complete monthly load bank testing and weekly inspection/testing of the generator. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance inspection tool and the TELs maintenance schedule for monthly load bank testing will be monitored by the Maintenance Director or designee monthly for 6 months. The Quality Assurance inspection tool and the TELs maintenance schedule for the weekly inspection/testing for the generator will be completed weekly by the Maintenance Director or designee for 4 weeks, monthly for 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months. Frequency and duration of reviews	

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	August 23 and October 4, 2024. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		will be increased as needed if any areas of noncompliance are identified during the auditing process.	
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: 10/09/24 Facility Number: 000239 Provider Number: 155348 AIM Number: 100290150 At this Life Safety Code survey, Parkview Care Center 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 (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 99 and had a census of 81 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	K 0000	October 27, 2024 Brenda Buroker Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Parkview Care Center Life Safety Survey ID 4N0S21 Dear Ms. Buroker; On October 9, 2024 a Life Safety Code Recertification and Emergency Preparedness 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	

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	garage used for maintenance and facility storage. Quality Review completed on 10/15/24		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 October 27, 2024 to the State findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on October 9, 2024. 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 Parkview Care Center	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure exit signage was visible at 1 of over 10 areas of exit discharge in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an	K 0293	K-293 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* exit signage was placed in the Holly unit to ensure	10/27/2024

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	approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over 10 residents and staff in the Holly Unit. Findings include: Based on observations on 10/09/24 between 2:15 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, there was an illuminated EXIT sign located above the smoke barrier door at the west end of the Holly Unit, however, this EXIT sign was not visible when moving towards the east end of the Holly Unit corridor due to a bulk head from the ceiling approximately 8 to 10 feet to the east of the smoke barrier doors. Based on interview at the time of observation, the Maintenance Director and Maintenance Assistant agreed the EXIT sign was not visible while moving towards the east end of the corridor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		visibility in the area of exit discharge from all directions. No resident experienced a negative outcome due to exit sign visibility. *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 LSC 7.10. The Maintenance Director and Executive Director completed a visual inspection of all exit signage to ensure visibility from all directions. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created for the Maintenance Director to complete visual inspection of all exit signage and placed in the TELs system to be completed monthly. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool was created and will be completed along with the TELs maintenance schedule for dry sprinkler system's pressure gauges and control valves will be completed and monitored weekly for 4 weeks, monthly for 5 months by the Maintenance Director or deginee. The results of these reviews will be discussed at the monthly facility	

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			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 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was documentation provided regarding an annual fire	K 0345	K-345 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* Tri-State Fire, the facility's fire alarm inspection vendor, completed a quarterly inspection on October 22, 2024 to include information about a semi-annual visual inspection of the facility's fire alarm devices. 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 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. *3.) The measures that have been put into place to ensure that the*	10/27/2024

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	alarm system inspection dated 04/23/24 by the facility's fire alarm inspection vendor, furthermore, there were quarterly inspections available dated 10/06/23, 01/24/24, and 07/29/24 by the facility's fire alarm inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors and heat detectors. For each device listed on each of the quarterly reports it said "Not Tested". The facility's pull stations were tested during each quarterly inspection. Based on interview at the time of record review, the Executive Director agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors and heat detectors. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		*deficient practice does not recur is* an inspection tool was created for the Maintenance Director to complete quarterly when reviewing the facility's fire alarm inspection vendors, quarterly reports to ensure the facility's fire alarm devices are tested semi-annually. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance visual inspection tool will be completed and monitored monthly for 6 months by Maintenance Director or designee. 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.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include:	K 0346	K-346 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a time frame for stating the fire watch if the fire alarm system is out of service, the contact information for ISOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway, and the	10/27/2024

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	Based on record review on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include the following: a. A time frame for starting the fire watch if the fire alarm system is out of service. b. Contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway, as well as contact information for the local Fire Department, and other required notifications. Based on an interview at the time of record review, this was confirmed by the Executive Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		contact information for the local Fire Department was placed in the fire watch policy. No resident experienced a negative outcome due to contact information not being in the fire watch policy. *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 LSC, Section 9.6.1.6. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created for the Maintenance Director to complete visual inspection of the fire watch policy monthly. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance inspection tool will be completed and monitored monthly for 6 months by the Maintenance Director or designee. 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 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include the following: a. A time frame for starting the fire watch if the sprinkler system is out of service. b. Contacting the IDOH with the web link for	K 0354	K-354 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a time frame for stating the fire watch if the fire alarm system is out of service, the contact information for ISOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway, and the contact information for the local Fire Department was placed in the fire watch policy. No resident experienced a negative outcome due to contact information not being in the fire watch policy. *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 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25). *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created for the Maintenance Director to complete visual inspection of the fire watch policy monthly. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the	10/27/2024

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	contacting the Incident Reporting System located on the IDOH Gateway, as well as contact information for the local Fire Department, Insurance Company, and other required notifications. Based on an interview at the time of record review, this was confirmed by the Executive Director. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		Quality Assurance inspection tool will be completed and monitored monthly for 6 months by the Maintenance Director or designee. 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.	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to inspect 4 of 36 portable fire extinguishers monthly. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual	K 0355	K-355 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* portable fire extinguishers in the laundry room, the satellite room, east end of Holly unit and Dogwood Unit Nurses Station were visually inspected by the Maintenance Director on October 11, 2024. 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 NFPA 10,	10/27/2024

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	inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 10/09/24 between 2:15 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the following was noted: a. The portable ABC fire extinguisher in the washer portion of the Laundry Room was not inspected monthly in July, August, and September of 2024. b. The portable ABC fire extinguisher in the Satellite Room was not inspected monthly in July, August, and September of 2024. c. The portable ABC fire extinguisher at the east end of the Holly Unit was not inspected monthly in September of 2024. d. The portable ABC fire extinguisher near the Dogwood Unit Nurse's Station was not inspected monthly in August and September of 2024. The annual inspection for all fire extinguishers by the facility's vendor was performed 02/29/24. Based on interview at the time of observations,		Standard for Portable Fire Extinguishers, Section 7.2.1.2 and Section 7.2.2. The Maintenance Director completed a visual inspection of all portable fire extinguishers in the facility. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created and placed in the TELs system for the Maintenance Director to complete visual inspection of all portable fire extinguishers within the facility monthly. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance visual inspection tool will be monitored monthly for 6 months then quarterly for 2 quarters by the Maintenance Director or designee. 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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	the Maintenance Director acknowledged the four portable fire extinguishers in question had not been inspected monthly as required. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and	K 0711	K-711 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a floor plan where the smoke barrier walls are within the facility was placed in the Emergency Preparedness Books behind the facility's fire plan and any information on battery smoke detectors was removed. No resident experienced any negative outcome. *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 was educated on NFPA 101, 2012 edition, Section 19.7.2.2 requiring a written health care occupancy fire safety plan. The facility's fire safety plan was updated. *3.) The measures that have been put into place to ensure that the*	10/27/2024

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	training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire plan on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, the following was noted: a. The plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. c. The plan addressed staff response to battery powered smoke detectors, however, the facility is not equipped with battery powered smoke detectors, only hard wired smoke detectors that are addressable to the fire alarm control panel. Based on interview at the time of record review, the Executive Director acknowledged and agreed that the Fire plan did not identify where the smoke barriers were located in the facility, the use of the K Class fire extinguisher in the kitchen, and that the facility was not equipped with battery powered smoke detectors. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		*deficient practice does not recur is* a visual inspection tool was created for the Maintenance Director to complete monthly upon review of the facility's fire safety plan. *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 Maintenance Director or designee to review fire safety plan 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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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 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 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no fire drill documentation available for the second shift (evening) of the third quarter (July, August, and September) of 2024. Based on interview at the time of record review, the Executive Director said she knows there was a fire drill performed during the second shift of the third quarter (August) of 2024, but the paperwork could not be located. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 4 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	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 2nd shift in 3rd quarter of 2024. No resident experienced a negative outcome due to missed fire drills. *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 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 visual inspection tool was created for the Maintenance Director to complete upon review of the facility's fire safety plan. *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 Maintenance Director or designee 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	10/27/2024

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	simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, all four third shift 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. Based on interview at the time of record review, the Executive Director confirmed there was no information included with 4 of 11 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3-1.19(b) 3.1-51(c)		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 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were allowed to be smoked by residents and staff. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 10/09/24 between 2:15 p.m. and 4:15 p.m. during a tour of the facility with	K 0741	K-741 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a metal self-closing cigarette butt can was placed in the smoking area. The cigarette butts were removed from the trash can in the smoking area and the trash can was cleaned. No resident experienced any negative	10/27/2024

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	the Maintenance Director and Maintenance Assistant, the following was noted: a. The Courtyard Gazebo, which is the designated smoking area, had a metal cigarette butt can full of paper trash and over 100 cigarette butts. Furthermore, the cigarette butt can was provided with a metal cover, however, it was not self closing. b. There was a large trash receptacle in the Courtyard next to the entrance/exit door (from the short hall between the Holly Unit and dining room) with paper trash and cigarette butts. When asked how staff disposes of cigarette butts from the cigarette ashtrays from the smoking area, the Maintenance Director said they were emptied into the large trash receptacle. Based on interview at the time of each observation, the Maintenance Director and Maintenance Assistant acknowledged the cigarette butts and paper trash in the metal can and large trash receptacle within the Courtyard smoking area. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		outcomes. *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 was educated on NFPA 101, 18.7.4 and 19.7.4. Facility staff was educated on proper disposal of cigarette butts. *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 Maintenance Director or designee 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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K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was 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, 5.2.4.1 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 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.	K 0761	K-761 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* a the oxygen room door was visually inspected by the Maintenance Director. No resident experienced any negative outcome. *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 was educated on LSC 19.1.1.4.1.1, LSC 8.3.3.1 and NFPA 80, 5.2.4.2. The Maintenance Director completed a visual inspection of the oxygen room door. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created and placed in the TELs system for the Maintenance Director to complete visual inspection of all fire doors within the facility monthly. *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 Maintenance Director or designee to complete monthly for 6 months	10/27/2024

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	(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 full 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 at least 10 residents, as well as staff, and visitors. Findings include: Based on record review on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Executive Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly available to review. Based on observations during a tour of the facility between 2:15 p.m. and 4:15 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		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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K 0914 SS=F Bldg. 01	3.1-19(b) NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period. Based on interview at the time of record review, the	K 0914	K-914 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the Maintenance Director completed electrical receptacle testing in all resident rooms. No resident experiences any negative outcomes. *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 was educated on NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3. The Maintenance Director completed electrical receptacle testing in all resident rooms. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created and placed in the TELs system for the Maintenance Director to complete electrical receptacle testing at least annually. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	10/27/2024

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	Maintenance Director said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew with a few exceptions from when a receptacle had to be replaced. The Executive Director said she could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period. Based on observations between 2:15 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		designed and implemented for the Maintenance Director or designee to complete 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 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 2 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010	K 0918	K-918 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the facility completed generator load testing and inspection/testing of the generator serving the emergency electrical system of the facility on October 25, 2024. No resident experienced a negative outcome due to missed written record of monthly testing. *2.) The corrective action taken for the other residents that have the potential to be affected by the*	10/27/2024

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	155348	A. BUILDING 01 B. WING	10/09/2024

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
	Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no monthly generator load test documentation available for August and September of 2024 for the emergency generator. Based on interview at the time of record review, the Executive Director confirmed there was no monthly load test documentation available for August and September of 2024. 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 a written record of weekly inspections for 1 of 1 generator was maintained for 5 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA		*same deficient practice is* all residents have the potential to be affected by this alleged deficient practice. The Maintenance Director was educated on 2012 NFPA 99 Chapter 6.4.4.1.1.4(a), NFPA 110, the Standard for Emergency and Standby Powers System, Chapter 8., Chapter 6-4.4.1.3 of 2012 NFPA 99, NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems 8.3.7 and 8.3.7.2, and Chapter 6.5.4.2 of NFPA. The Maintenance Director completed a generator load test and inspection/testing of the emergency generator. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* the monthly inspection schedule for the load bank testing of the generator and the weekly inspection/testing for the generator was placed into the TELs system for the Maintenance Director to complete timely. An inspection tool was created for the Maintenance Director to complete monthly load bank testing and weekly inspection/testing of the generator. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance inspection tool and TELs maintenance schedule for monthly load bank testing will be monitored monthly for 6	

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	99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 10/09/24 between 9:15 a.m. and 2:15 p.m. and again between 4:15 p.m. and 5:30 p.m. with the Executive Director and Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly between August 23 and October 4, 2024. Based on interview at the time of record review, the Executive Director confirmed there was no weekly generator inspection/testing documentation available for review between August 23 and October 4, 2024. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		months by the Maintenance Director or desginee. The Quality Assurance inspection tool and TELs maintenance schedule for the weekly inspection/testing for the generator will be completed weekly for 4 weeks, monthly for 5 months by the Maintenance Director or designee. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months. 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 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips and extension cords were not used as a substitute for fixed wiring in 1 of over 50 resident rooms and 4 staff rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, 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 least two residents and multi staff. Findings include: Based on observations on 10/09/24 between 2:15 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the following was noted: a. The Staff Development Office had a refrigerator and microwave oven plugged into a power strip. b. The Holly Unit Nurse's Station had a window AC unit plugged into a power strip. c. The Infectious Disease Office had a microwave oven plugged into an extension cord. d. Room 215 had a refrigerator plugged into a power strip. e. The Cherry Lane Unit Med Room had a refrigerator plugged into a multi plugged extension cord. This was acknowledged by the Maintenance Director and Maintenance Assistant at the time of each observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.	K 0920	K-920 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the power strip and/or extension cord was removed from the Staff Development Office, Holly Unit Nurse's Station, Infectious Disease Office, room 215 and Cherry Lane Unit Med Room. No resident experienced a negative outcome. *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 LSC 19.5.1, LSC 9.1.2, NFPA 70, National Electrical Code, 2011 Edition. The Maintenance Director completed a visual inspection of facility offices and resident rooms to ensure any power strip used for PCREE meet UL 1363A or UL 60601-1 and non-PCREE meet UL 1363. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* an inspection tool was created for the Maintenance Director to complete monthly for visual inspection of all facility offices and resident rooms to ensure power	10/27/2024

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	3.1-19(b)		strips and extension cords are not being used as a substitute for fixed wiring.. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance inspection tool and the TELs maintenance schedule for monthly load bank testing will be monitored monthly for 6 months by the Maintenance Director or designee. The TELs maintenance schedule for the weekly inspection/testing for the generator will be completed weekly for 4 weeks, monthly for 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	