CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/09/2024	
	PROVIDER OR SUPPLIER			2819 N	ADDRESS, CITY, STATE, ZIP COD IORTH ST JOSEPH AVE SVILLE, IN 47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 10/09 Facility Number: 0 Provider Number: 100 At this Emergency Care Center was for Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 99 the survey, the cens	20/24 200239 155348 290150 Preparedness survey, Parkview und not in compliance with edness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of sus was 81. mpleted on 10/15/24 42 CFR, Subpart 483.73 is NOT	E 00	000	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 Saf Code Recertification and Emergency Preparedness Sur was conducted at our facility. submitting the enclosed mater Parkview Care Center nor its management company are no admitting the truth or accuracy any specific findings or allegations. Parkview Care Coreserves the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our	fety rvey By rial, of enter ne of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

regulatory obligations. The facility

(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 natients (see instructions.) Except for pursing homes, the findings stated above are disclosable.

Any deflencystatement ending with an asterisk (\*) denotes a deflection which the institution may be excused from correcting providing it is determined the 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 disclosed 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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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/09/2024
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP COD IORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				requests the plan of correction considered our allegation of compliance effective October 2024 to the State findings of t Life Safety Code Recertification and Emergency Preparednes Survey conducted on October 2024. Parkview Care Center respectfully requests a desk review.  Please feel free to contact the facility if any additional inform is needed.  Respectfully submitted,	27, he on s - 9,
E 0041 SS=F		(e), 485.542(e), 485.62 LTC Emergency Power		Krista Adams, B.S.N., R.N. F Executive Director Parkview Care Center	IFA
Bldg	failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2).  1. Based on record facility failed to ma of monthly generate generator during 2 of	riew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42  review and interview, the intain a complete written record or load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly	E 0041	This Plan of Correction is to s as Parkview Care Center's credible allegation of complian By submitting the enclosed materials, Parkview Care Cernor it's management company not admitting the truth or accurof any specific findings or allegations. Parkview Care Creserves the right to contest the findings or allegations as part any proceedings and submit to	nce.  Iter  I are  Iracy  enter  ne  of

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155348		A. BUILDING  B. WING			COMPLETED 10/09/2024			
NAME OF I	PROVIDER OR SUPPLIEF	}	STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE					
PARKVII	EW CARE CENTER	1	EVANSVILLE, IN 47720					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION ator serving the emergency	+	TAG			DATE	
		be in accordance with NFPA			responses pursuant to our regulatory obligations. The fa	cility		
		or Emergency and Standby			requests the plan of correction	-		
	Powers Systems, Chapter 8. Chapter 6.4.4.2 of				considered our allegation of			
	NFPA 99 requires a written record of inspection,				compliance effective October	27,		
	performance, exercising period, and repairs for the				2024 to the state findings of th			
	generator to be regularly maintained and available				Life Safety Code Recertification	n		
	for inspection by th				and State Licensure conducte	d on		
	jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99				October 9, 2024. Parkview Ca	are		
	requires batteries for on-site generators shall be				Center respectfully requests a			
	maintained in accordance with NFPA 110, 2010				desk review.			
	Edition, Standard for Emergency and Standby				E-041			
	Power Systems. 8.3.7 requires storage batteries,				1.) The corrective action take	n for		
	including electrolyte levels or battery voltage, used in connection with systems shall be				those residents found to have			
		-			been affected by the deficient			
		nd maintained in full			practice is the facility complete			
	_	anufacturer's specifications. tive batteries shall be repaired			generator load testing and	otor		
		ately upon discovery of			inspection/testing of the gener serving the emergency electric			
		5.4.2 of NFPA 99 requires a			system of the facility on Octob			
	_	spection, performance,			1 -	CI		
		and repairs shall be regularly	25, 2024. No resident					
		ilable for inspection by the	experienced a negative outcome due to missed written record of					
		risdiction. This deficient		monthly testing.				
		et all residents, staff and	2.) The corrective action taken for					
	visitors.		the other residents that have the					
					potential to be affected by the			
	Findings include:				same deficient practice is all			
					residents have the potential to			
		the generator inspection and			affected by this alleged deficie	nt		
	~ ^	0/09/24 between 9:15 a.m. and			practice. The Maintenance			
		between 4:15 p.m. and 5:30			Director was educated on 201			
	_	ntive Director and Maintenance			NFPA 99 Chapter 6.4.4.1.1.4(	a),		
	_	ere was no monthly generator			NFPA 110, the Standard for			
		ation available for August and			Emergency and Standby Pow	ers		
		for the emergency generator.			System, Chapter 8., Chapter			
		at the time of record review,			6-4.4.1.3 of 2012 NFPA 99, N			
		ctor confirmed there was no ocumentation available for			110, 2010 Edition, Standard for			
	August and Septem				Emergency and Standby Pow Systems 8.3.7 and 8.3.7.2, an			
	1 rugust and septem	001 01 2027.	1		Dysterns o.s.r and o.s.r.z, an	u	1	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155348	B. W	ING		10/09/	2024
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ORTH ST JOSEPH AVE		
PΔRK\/II	EW CARE CENTER				SVILLE, IN 47720		
I AININI	-W CARL CLIVILI	<b>\</b>		LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					Chapter 6.5.4.2 of NFPA. The		
		eviewed with the Executive			Maintenance Director comple	ted a	
		enance Director during the exit			generator load test and		
	conference.				inspection/testing of the		
					emergency generator.		
		review and interview, the			3.) The measures that have t		
	facility failed to ensure a written record of weekly				put into place to ensure that ti		
	inspections for 1 of 1 generator was maintained				deficient practice does not red		
	for 5 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA				the monthly inspection schedu		
	99 requires batteries for on-site generators shall				for the load bank testing of the	9	
	be maintained in accordance with NFPA 110, 2010				generator and the weekly		
	Edition, Standard for Emergency and Standby				inspection/testing for the gene	erator	
	Power Systems. 8.3.7 requires storage batteries,				was placed into the TELs syst	tem	
		te levels or battery voltage,			for the Maintenance Director t	ю	
		with systems shall be			complete timely. An inspection	n	
		nd maintained in full			tool was created for the		
	_	anufacturer's specifications.			Maintenance Director to comp	olete	
		tive batteries shall be repaired			monthly load bank testing and	l	
	_	ately upon discovery of			weekly inspection/testing of the	ie	
	_	5.4.2 of NFPA 99 requires a			generator.		
		spection, performance,			4.) The corrective action take	n to	
		and repairs shall be regularly			monitor to ensure the deficien	-	
		ilable for inspection by the			practice will not recur is that the		
		risdiction. This deficient			Quality Assurance inspection	tool	
	-	et all residents, staff and			and the TELs maintenance		
	visitors.				schedule for monthly load bar		
					testing will be monitored by th		
	Findings include:				Maintenance Director or design		
					monthly for 6 months. The Qu	- 1	
		the generator inspection and			Assurance inspection tool and		
		0/09/24 between 9:15 a.m. and			TELs maintenance schedule f		
		n between 4:15 p.m. and 5:30			the weekly inspection/testing		
	_	utive Director and Maintenance			the generator will be complete	ed	
	•	ere was no documentation			weekly by the Maintenance	.	
		he emergency generator was			Director or designee for 4 week		
		eekly between August 23 and			monthly for 5 months. The re		
		Based on interview at the time of			of these reviews will be discus	ssed	
		Executive Director confirmed			at the monthly facility QAPI		
		y generator inspection/testing			meeting monthly for 6 months		
	documentation ava	ilable for review between	1		Frequency and duration of rev	/iews	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED
		155348	B. W	ING		10/09/2024
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF P	ROVIDER OR SUPPLIEI	R			ORTH ST JOSEPH AVE	
PARKVIE	W CARE CENTER	₹			SVILLE, IN 47720	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE COMITEE TON
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	August 23 and Octo	ober 4, 2024.			will be increased as needed i	if any
	TELL: (* 1.	t talal m			areas of noncompliance are	
	_	eviewed with the Executive			identified during the auditing	
	conference.	enance Director during the exit			process.	
	conference.					
K 0000						
Bldg. 01						
J. J.	A Life Safety Code	e Recertification and State	K 0	000		
	-	vas conducted by the Indiana	0			
	Department of Hea	lth in accordance with 42 CFR				
	483.90(a).				October 27, 2024	
	Survey Date: 10/09/24				Brenda Buroker	
	Barvey Bare. 10/0.	721			Director Division of Long Terr	m
	Facility Number: (	000239			Care	
	Provider Number:				Indiana State Department of	
	AIM Number: 100	0290150			Health	
					2 North Meridian Street	
	At this Life Safety	Code survey, Parkview Care			Indianapolis, IN 46204	
	Center was found n	not in compliance with				
	Requirements for P	Participation in				
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),				
	_	ire and the 2012 edition of the			RE: Parkview Care Center	
		ection Association (NFPA) 101,			Life Safety Survey ID	
	Life Safety Code (I	LSC), Chapter 19, Existing			4N0S21	
	Health Care Occup	ancies and 410 IAC 16.2.				
	This one-story facil	lity was determined to be of			Dear Ms. Buroker;	
	Type V (000) const	truction and was fully				
	sprinklered. The fa	acility has a fire alarm system			On October 9, 2024 a Life Sa	afety
		oke detectors in the corridors,			Code Recertification and	
		corridors, and all resident			Emergency Preparedness Su	- I
		ne facility has a capacity of 99			was conducted at our facility.	•
	and had a census of	f 81 at the time of this survey.			submitting the enclosed mate	
					Parkview Care Center nor its	
		idents have customary access			management company are no	
		nd all areas providing facility			admitting the truth or accurac	cy of
	services were sprin	klered, except one detached			any specific findings or	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLA	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	FTFD
		155348				COMPLETED	
		133340	B. WI	NG		10/09/	2024
	PROVIDER OR SUPPLIE			2819 N	ADDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE VILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<b>I</b>	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE
	garage used for ma	intenance and facility storage.			allegations. Parkview Care Ce	enter	
					reserves the right to contest th	ie	
	Quality Review co	mpleted on 10/15/24			findings or allegations as part	of	
					any proceedings and submit th	nese	
					responses pursuant to our		
					regulatory obligations. The fac	-	
					requests the plan of correction	be	
					considered our allegation of	27	
					compliance effective October 2 2024 to the State findings of the		
					Life Safety Code Recertification		
					and Emergency Preparedness		
					Survey conducted on October		
					2024. Parkview Care Center	-,	
					respectfully requests a desk		
					review.		
					Please feel free to contact the		
					facility if any additional informa		
					is needed.		
					Respectfully submitted,		
					Krista Adams, B.S.N., R.N. H Executive Director Parkview Care Center	FA	
K 0293	NFPA 101						
SS=E Bldg. 01	Exit Signage						
Blag. 01	failed to ensure exi over 10 areas of ex LSC 7.10. LSC 7. exterior exit doors	on and interview, the facility t signage was visible at 1 of it discharge in accordance with 10.1.2.1 exits, other than main that obviously and clearly are s, shall be marked by an	K 02	293	K-293 1.) The corrective action taken those residents found to have been affected by the deficient practice is exit signage was placed in the Holly unit to ensu		10/27/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/09/2024 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE approved sign that is readily visible from any visibility in the area of exit direction of exit access. LSC 7.10.1.2.2 states discharge from all directions. No horizontal components of the egress path within resident experienced a negative an exit enclosure shall be marked by approved exit outcome due to exit sign visibility. or directional exit signs where the continuation of 2.) The corrective action taken for the egress path is not obvious. This deficient the other residents that have the practice could affect over 10 residents and staff in potential to be affected by the the Holly Unit. same deficient practice is all residents have the potential to be Findings include: affected by this alleged deficient practice. The Maintenance Based on observations on 10/09/24 between 2:15 Director was educated on LSC p.m. and 4:15 p.m. during a tour of the facility with 7.10. The Maintenance Director the Maintenance Director and Maintenance and Executive Director completed Assistant, there was an illuminated EXIT sign a visual inspection of all exit located above the smoke barrier door at the west signage to ensure visibility from all end of the Holly Unit, however, this EXIT sign directions. was not visible when moving towards the east 3.) The measures that have been end of the Holly Unit corridor due to a bulk head put into place to ensure that the from the ceiling approximately 8 to 10 feet to the deficient practice does not recur is east of the smoke barrier doors. Based on an inspection tool was created for interview at the time of observation, the the Maintenance Director to Maintenance Director and Maintenance Assistant complete visual inspection of all agreed the EXIT sign was not visible while exit signage and placed in the moving towards the east end of the corridor. TELs system to be completed monthly. This finding was reviewed with the Executive 4.) The corrective action taken to Director and Maintenance Director during the exit monitor to ensure the deficient conference. practice will not recur is that a Quality Assurance tool was 3.1-19(b) 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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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	ľ í	JILDING	ONSTRUCTION (X3) DATE SURVEY  O1 COMPLETED  10/09/2024		LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720		IORTH ST JOSEPH AVE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					QAPI meeting monthly for 6 months and then quarterly for quarters. Frequency and dur of reviews will be increased a needed if any areas of noncompliance are identified during the auditing process.	ation	
K 0345 SS=F Bldg. 01	failed to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual inspe accordance with the more often if requirigurisdiction. Table must be visually instance and the control unit troubles. Remote annunciated in the facility.  Initiating devices fire alarm boxes, he etc.)  Individually instance and the control unit troubles. Remote annunciated in the facility.  Initiating devices fire alarm boxes, he etc.)  Initiating devices fire alarm boxes, he etc.)	riew and interview, the facility of 1 fire alarm system in PA 72, as required by LSC 101 and 9.6. NFPA 72, Section less otherwise permitted by ctions shall be performed in eschedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following spected semi-annually: ble signals tors  (e.g. duct detectors, manual at detectors, smoke detectors,	K 0	345	K-345  1.) The corrective action take 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, 202 include information about a semi-annual visual inspection the facility's fire alarm devices. No resident experienced a negative outcome due to overlooked inspections.  2.) The corrective action take the other residents that have potential to be affected by the same deficient practice is all residents have the potential to affected by this alleged deficient practice. The Maintenance Director was educated on NF 70, National Electric Code an NFPA 72, National Fire Alarm Signaling Code.	e t  y 24 to 25 of s.  en for the e ent PA	10/27/2024

Maintenance Director present, there was

documentation provided regarding an annual fire

3.) The measures that have been

put into place to ensure that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CO A. BUILDING B. WING	01	X3) DATE SURVEY COMPLETED 10/09/2024	
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION
TAG	alarm system inspection there were quarterly 10/06/23, 01/24/24, fire alarm inspection quarterly inspection information about a of the facility's fire detectors and heat delisted on each of the Tested". The facility during each quarter interview at the tim Executive Director inspections did not semi-annual visual alarm system device and heat detectors.  This finding was re-	etion dated 04/23/24 by the inspection vendor, furthermore, inspections available dated and 07/29/24 by the facility's in vendor, however, the documents did not provide semi-annual visual inspection alarm devices, such as smoke detectors. For each device equarterly reports it said "Not try's pull stations were tested ly inspection. Based on the of record review, the agreed the quarterly provide information of a inspection of the facility's fire the est, such as smoke detectors.	TAG	deficient practice does not rect an inspection tool was created the Maintenance Director to complete quarterly when review the facility's fire alarm inspection vendors, quarterly reports to ensure the facility's fire alarm devices are tested semi-annual 4.) The corrective action taken monitor to ensure the deficient practice will not recur is that a Quality Assurance visual inspection tool will be complete and monitored monthly for 6 months by Maintenance Direct or designee. The results of the reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters. Frequency and duration of reviewill be increased as needed if areas of noncompliance are identified during the auditing process.	wing on ally.  at to to tese ee  iews
K 0346 SS=F Bldg. 01	failed to provide a control protection of all occurs to be followed in the has to be placed out more in a twenty for	view and interview, the facility complete written policy for the cupants indicating procedures to event the fire alarm system to f service for four hours or the ur hour period in accordance 0.6.1.6. This deficient practice	K 0346	K-346 1.) The corrective action taker those residents found to have been affected by the deficient practice is a time frame for stathe fire watch if the fire alarm system is out of service, the contact information for ISOH with eweb link for contacting the Incident Reporting System local	ting <i>r</i> ith

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155348	B. W	ING		10/09/	2024
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					ORTH ST JOSEPH AVE		
PARKVIE	EW CARE CENTER			EVANS	SVILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		view on 10/09/24 between 9:15			contact information for the loca		
	_	and again between 4:15 p.m. and			Fire Department was placed in	n the	
	-	Executive Director and			fire watch policy. No resident		
		for present, the facility did documentation, however, it was			experienced a negative outcor		
	-	an failed to include the		due to contact information not			
	following:	an failed to include the			being in the fire watch policy.  2.) The corrective action take.	n for	
	a. A time frame for starting the fire watch if the				the other residents that have t		
	a. A time frame for starting the fire watch if the fire alarm system is out of service.				potential to be affected by the	110	
	b. Contacting the IDOH with the web link for				same deficient practice is all		
	b. Contacting the IDOH with the web link for contacting the Incident Reporting System located				residents have the potential to	be	
	on the IDOH Gateway, as well as contact				affected by this alleged deficie		
	information for the local Fire Department, and				practice. The Maintenance		
	other required notif	ications.			Director was educated on LSC	Σ,	
	Based on an intervi	ew at the time of record review,			Section 9.6.1.6.		
	this was confirmed	by the Executive Director.			3.) The measures that have b	een	
					put into place to ensure that th	ne	
	This finding was re	viewed with the Executive			deficient practice does not rec	ur is	
	Director and Mainte	enance Director during the exit			an inspection tool was created	l for	
	conference.				the Maintenance Director to		
					complete visual inspection of t	he	
	3.1-19(b)				fire watch policy monthly.		
					4.) The corrective action take		
					monitor to ensure the deficien		
					practice will not recur is that the		
					Quality Assurance inspection		
					will be completed and monitor	ed	
					monthly for 6 months by the		
					Maintenance Director or		
					designee. The results of these reviews will be discussed at the		
					monthly facility QAPI meeting	e	
					monthly for 6 months and ther	,	
					quarterly for 2 quarters.	•	
					Frequency and duration of rev	iews	
					will be increased as needed if		
					areas of noncompliance are		
					identified during the auditing		
					process.		
					'		

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10/29/2024 PRINTED: FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/09/2024 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0354 **NFPA 101** SS=F Sprinkler System - Out of Service Bldg. 01 Based on record review and interview, the facility K 0354 K-354 10/27/2024 failed to provide a complete written policy 1.) The corrective action taken for containing procedures to be followed for the those residents found to have protection of all occupants in the event the been affected by the deficient automatic sprinkler system has to be placed practice is a time frame for stating out-of-service for 10 hours or more in a 24-hour the fire watch if the fire alarm period in accordance with LSC, Section 9.7.5. LSC system is out of service, the 9.7.6 requires sprinkler impairment procedures contact information for ISOH with comply with NFPA 25, 2011 Edition, the Standard the web link for contacting the for the Inspection, Testing and Maintenance of Incident Reporting System located Water-Based Fire Protection Systems. NFPA 25, on the IDOH Gateway, and the 15.5.2 requires nine procedures that the contact information for the local impairment coordinator shall follow. A.15.5.2 (4) Fire Department was placed in the (b) states a fire watch should consist of trained fire watch policy. No resident personnel who continuously patrol the affected experienced a negative outcome area. Ready access to fire extinguishers and the due to contact information not ability to promptly notify the fire department are being in the fire watch policy. important items to consider. During the patrol of 2.) The corrective action taken for the area, the person should not only be looking the other residents that have the for fire, but making sure that the other fire potential to be affected by the protection features of the building such as egress same deficient practice is all routes and alarm systems are available and residents have the potential to be functioning properly. This deficient practice affected by this alleged deficient could affect all occupants in the facility. practice. The Maintenance

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

(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.

Director was educated on

18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2

4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that the

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155348 B. WING 10/09/2024

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE

PARKVIEW CARE CENTER			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		
K 0355 SS=F Bldg. 01	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)  NFPA 101  Portable Fire Extinguishers		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.			
Bidg. 01	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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155348	B. W	ING		10/09/	
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
D A D I O // E	NA OADE OENTED				ORTH ST JOSEPH AVE		
PARKVIE	EW CARE CENTER			EVANS	VILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	inspections shall ke	ep records of all fire			Standard for Portable Fire		
	extinguishers inspec	cted, including those found to			Extinguishers, Section 7.2.1.2	and	
	require corrective a	ction. Section 7.2.4.3 requires			Section 7.2.2. The Maintenan	ice	
	where at least mont	hly manual inspections are			Director completed a visual		
	conducted, the date	the manual inspection was			inspection of all portable fire		
	performed and the i	nitials of the person			extinguishers in the facility.		
		ection shall be recorded.			3.) The measures that have b	een	
		nires where manual inspections			put into place to ensure that th	пе	
	are conducted, records for manual inspections				deficient practice does not rec	ur is	
	shall be kept on a tag or label attached to the fire				an inspection tool was created		
	extinguisher, on an inspection checklist				and placed in the TELs syster	n for	
	maintained on file, or by an electronic method.				the Maintenance Director to		
	Section 7.2.4.5 requires records shall be kept to				complete visual inspection of	all	
		least the last 12 monthly			portable fire extinguishers with	nin	
	_	en performed. This deficient			the facility monthly.		
	practice could affec	t all residents, staff and			4.) The corrective action take	n to	
	visitors.				monitor to ensure the deficien	t	
					practice will not recur is that the	ne	
	Findings include:				Quality Assurance visual		
					inspection tool will be monitore	ed	
		ons on 10/09/24 between 2:15			monthly for 6 months then		
		during a tour of the facility with			quarterly for 2 quarters by the		
		rector and Maintenance			Maintenance Director or		
	Assistant, the follow	· ·			designee. The results of these		
	_	C fire extinguisher in the			reviews will be discussed at th	ne	
	_	ne Laundry Room was not			monthly facility QAPI meeting		
		n July, August, and			monthly for 6 months and ther	า	
	September of 2024.				quarterly for 2 quarters.		
	_	C fire extinguisher in the			Frequency and duration of rev		
		not inspected monthly in July,			will be increased as needed if	any	
	August, and Septen				areas of noncompliance are		
		C fire extinguisher at the east			identified during the auditing		
		nit was not inspected monthly			process.		
	in September of 202						
	_	C fire extinguisher near the					
	_	se's Station was not inspected					
	1 -	and September of 2024.					
		on for all fire extinguishers by					
		was performed 02/29/24.					
	Based on interview	at the time of observations,	1				

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155348 B. WING 10/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE PARKVIEW CARE CENTER **EVANSVILLE. IN 47720** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 **NFPA 101** SS=F Evacuation and Relocation Plan Bldg. 01 Based on record review and interview, the facility K 0711 K-711 10/27/2024 failed to provide a complete facility specific 1.) The corrective action taken for written fire safety plan for the protection of all those residents found to have residents to accurately address all life safety been affected by the deficient systems, plus a system addressing all items practice is a floor plan where the required by NFPA 101, 2012 edition, Section smoke barrier walls are within the 19.7.2.2. LSC 19.7.2.2 requires a written health care facility was placed in the occupancy fire safety plan that shall provide for **Emergency Preparedness Books** the following: behind the facility's fire plan and (1) Use of alarms any information on battery smoke (2) Transmission of alarm to fire department detectors was removed. No (3) Emergency phone call to fire department resident experienced any negative (4) Response to alarms outcome. (5) Isolation of fire 2.) The corrective action taken for (6) Evacuation of immediate area the other residents that have the (7) Evacuation of smoke compartment potential to be affected by the (8) Preparation of floors and building for same deficient practice is all evacuation residents have the potential to be (9) Extinguishment of fire affected by this deficient practice. Section 19.2.3.4(4) states any required aisle or The Maintenance Director was corridor shall not be less than 48 inches in clear educated on NFPA 101, 2012 width where serving as means of egress from edition, Section 19.7.2.2 requiring patient sleeping rooms. Projections into the a written health care occupancy required width shall be permitted for wheeled fire safety plan. The facility's fire

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equipment provided the relocation of wheeled

addressed in the written fire safety plan and

equipment during a fire or similar emergency is

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safety plan was updated.

3.) The measures that have been

put into place to ensure that the

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  training program for the facility. The wheeled equipment is limited to:  i. Equipment in use and carts in use ii. 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.	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE	X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER  (X4) ID PREFIX TAG  IT SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  IT REGULATORY OR LSC IDENTIFYING INFORMATION  I 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.  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.  STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720  ID PREFIX TAG  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 for 6 months and then quarterly for 2 quarters.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REquipment 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.  STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720  (X5)  PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION  PREFIX TAG PROPRIATE COMPLETION COMPLETION DATE  ID PROVIDERS PLAN OF CORRECTION (X5)  COMPLETION DEMCASHCH ACTION SHOULD ACTION (EACH COMPLET ACTION SHOULD ACTION (CASH CHORN SHO			155348	B. W	NG		10/09/	/2024
CAS   DEPTICATION					_			
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIE   ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   Regulatory or local companies of the facility. The wheeled equipment is limited to:	NAME OF P	PROVIDER OR SUPPLIEF	8					
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use iii. 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.  ID PROVIDERS PLAN OF CORRECTION (AS) PREFIX								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency 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 compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail.  TAG  PREFIX	PARKVIE	EW CARE CENTER	2		EVANS	VILLE, IN 47720		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency 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 compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail.  PREFIX TAG  PAGETA	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
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.  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.  Tag Medical emergency 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.	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CODDECTIVE ACTION SHOULD DE	T-	COMPLETION
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.  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.	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
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.  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.		training program fo	r the facility. The wheeled			deficient practice does not rec	ur is	
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.  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 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 piractive will not recur is that a Quality Assurance tool has been designed and implemented for the monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been designed and implemented for the monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been designed and implemented for the monthly for 6 months then quarterly for 2 quarters.		equipment is limite	d to:			•		
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.  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.						•		
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.  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.							nog	
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.  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.		_					•	
in the event of an emergency.  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 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.  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.							,	
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.  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.		-	-			•	n to	
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.  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.						•		
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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.  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.		I mange morauti				•	en	
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.  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.		Based on a review of the facility's Fire plan on				-		
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.  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.		-						
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.  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.						_		
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.  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.							-	
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.  a udits will be discussed at the monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters.			-					
compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail.  monthly facility QAPI meeting monthly for 6 months and then quarterly for 2 quarters.		-				-		
where the smoke barriers were located in the facility and evacuation in detail.  monthly for 6 months and then quarterly for 2 quarters.		_						
facility and evacuation in detail. quarterly for 2 quarters.		-	-				1	
						-		
b. The use of the K-class fire extinguisher in the Frequency and duration of reviews		-				Frequency and duration of rev	iews	
kitchen in relationship with the use of the kitchen will be increased as needed if any								
overhead extinguishing system.  areas of noncompliance are			-				u.ry	
c. The plan addressed staff response to battery identified during the auditing						· ·		
powered smoke detectors, however, the facility is process.		•	•			-		
not equipped with battery powered smoke		-				process.		
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			<u> </u>					
the facility was not equipped with battery								
powered smoke detectors.								
Positions detectors.		pomerea smoke det						
This finding was reviewed with the Executive		This finding was re	viewed with the Executive					
Director and Maintenance Director during the exit		_						
conference.			S Diverse willing the Call					
		251110101100						
3.1-19(b)		3.1-19(b)						

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10/29/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/09/2024 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0712 **NFPA 101** SS=F Fire Drills Bldg. 01 1. Based on record review and interview, the K-712 K 0712 10/27/2024 facility failed to provide quarterly fire drill 1.) The corrective action taken for documentation for 1 of 3 shifts during 1 of 4 those residents found to have quarters. This deficient practice could affect all been affected by the deficient residents, as well as staff and visitors in the practice is a fire drill was facility. completed for 2nd shift in 3rd guarter of 2024. No resident Findings include: experienced a negative outcome due to missed fire drills. Based on review of the facility's fire drill reports 2.) The corrective action taken for on 10/09/24 between 9:15 a.m. and 2:15 p.m. and the other residents that have the again between 4:15 p.m. and 5:30 p.m. with the potential to be affected by the Executive Director and Maintenance Director same deficient practice is all present, there was no fire drill documentation residents have the potential to be available for the second shift (evening) of the affected by this deficient practice. third quarter (July, August, and September) of The Maintenance Director was 2024. Based on interview at the time of record educated on LSC 19.7.1.4 review, the Executive Director said she knows requiring fire drills to be completed there was a fire drill performed during the second every shift every quarter. shift of the third quarter (August) of 2024, but the 3.) The measures that have been paperwork could not be located. put into place to ensure that the deficient practice does not recur is This finding was reviewed with the Executive a visual inspection tool was Director and Maintenance Director during the exit created for the Maintenance conference. Director to complete upon review of the facility's fire safety plan. 3.1-19(b) 4.) The corrective action taken to 3.1-51(c)monitor to ensure the deficient practice will not recur is that a 2. Based on record review and interview, the Quality Assurance tool has been facility failed to ensure 4 of 11 fire drill reports designed and implemented for the included complete documentation of the Maintenance Director or designee transmission of a fire alarm signal to the to review fire drill documentation monitoring company/fire department during the monthly for 6 months then

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past twelve months. LSC 19.7.1.4 requires fire

transmission of the fire alarm signal and

drills in health care occupancies shall include the

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quarterly for 2 quarters. The

results of these audits will be

discussed at the monthly facility

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
155348		B. WING 10/09/2024			/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	-	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	simulation of emerg	gency conditions. This			QAPI meeting monthly for 6			
	deficient practice co	ould affect all residents.			months and then quarterly for	2		
	Findings include:				quarters. Frequency and duration of reviews will be increased as needed if any areas of			
	Based on review of	the facility's fire drill reports			noncompliance are identified			
	on 10/09/24 betwee	n 9:15 a.m. and 2:15 p.m. and			during the auditing process.			
	again between 4:15	p.m. and 5:30 p.m. with the						
		and Maintenance Director						
	_	rd shift fire drill reports						
		ne past 12 month period were						
	_	ocumentation for the						
		alarm to the monitoring						
		n interview at the time of						
		Executive Director confirmed						
		nation included with 4 of 11 fire						
	_	y that transmission of the						
	alarm was received	by the monitoring company.						
	_	viewed with the Executive enance Director during the exit						
	3-1.19(b)							
	3.1-51(c)							
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulati	ons						
	Based on observation and interview, the facility failed to ensure eigarette butts were properly		K 0'	741	K-741  1.) The corrective action taker	n for	10/27/2024	
	_	l area where cigarettes were			those residents found to have			
	allowed to be smok	ed by residents and staff. This			been affected by the deficient			
	deficient practice could affect at least 5 residents				practice is a metal self-closing			
	and staff.				cigarette butt can was placed	in		
	Findings include:				the smoking area. The cigare butts were removed from the t can in the smoking area and the smoking area.	rash		
	Based on observation	ons on 10/09/24 between 2:15			trash can was cleaned. No			
		during a tour of the facility with			resident experienced any negative			

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			ETED	
155348		B. WING 10/09/2024			/2024		
		<u> </u>		STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ORTH ST JOSEPH AVE		
	EW CARE CENTER				VILLE, IN 47720		
FARRVIE	-VV OANL CENTER			LVAINS	· · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		rector and Maintenance			outcomes.		
	Assistant, the follow	_			2.) The corrective action take	n for	
	-	azebo, which is the designated			the other residents that have t	he	
	-	metal cigarette butt can full of			potential to be affected by the		
		r 100 cigarette butts.			same deficient practice is all		
		garette butt can was provided			residents have the potential to		
		however, it was not self			affected by this deficient pract		
	closing.				The Maintenance Director was		
		e trash receptacle in the			educated on NFPA 101, 18.7.	4	
		ne entrance/exit door (from the			and 19.7.4. Facility staff was		
		he Holly Unit and dining			educated on proper disposal o	of	
	· · ·	ash and cigarette butts. When		cigarette butts.			
	-	poses of cigarette butts from	3.) The measures that have been		een		
		rs from the smoking area, the	put into place to ensure that the		ne		
		or said they were emptied into			deficient practice does not rec	ur is	
	the large trash recep		a fire drill calendar was created to				
	Based on interview		ensure a fire drill every month on				
	· ·	intenance Director and			three different shifts every qua	arter	
		ant acknowledged the			maintaining a 2 hour gap betw	/een	
		paper trash in the metal can			fire drills is scheduled.		
		ptacle within the Courtyard			4.) The corrective action take	n to	
	smoking area.				monitor to ensure the deficient	t	
					practice will not recur is that a		
		viewed with the Executive			Quality Assurance tool has be		
		enance Director during the exit			designed and implemented for		
	conference.				Maintenance Director or desig		
					to review fire drill documentati	on	
	3.1-19(b)				monthly for 6 months then		
					quarterly for 2 quarters. The		
					results of these audits will be		
					discussed at the monthly facili	ty	
					QAPI meeting monthly for 6		
					months and then quarterly for		
					quarters. Frequency and dura	ation	
					of reviews will be increased as	6	
					needed if any areas of		
					noncompliance are identified		
					during the auditing process.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		A. BUILDING 01 CO B. WING 10			COMPL	DATE SURVEY COMPLETED 10/09/2024		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION	
TAG  K 0761  SS=E  Bldg. 01	REGULATORY OR NFPA 101 Maintenance, Inspection and testin door assembly was LSC 19.1.1.4.1.1. Of dividing fire barrier permitted only in compare the second	pection & Testing - Doors  on, record review, and ty failed to ensure an annual and of 1 of 1 oxygen room fire completed in accordance with Communicating openings in as required by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies.  3.) LSC 8.3.3.1 Openings are protection rating by Table sected by approved, listed, semblies and fire window accompanying hardware, acclosing devices, anchorage, acce with the requirements of for Fire Doors and Other accept as otherwise de. NFPA 80 5.2.1 states fire and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both verall condition of door  attes as a minimum, the ll be verified: are breaks exist in surfaces of ame. light frames, and glazing beads ely fastened in place, if so	KO	TAG	K-761  1.) The corrective action taken those residents found to have been affected by the deficient practice is a the oxygen room door was visually inspected by Maintenance Director. No resident experienced any neg outcome.  2.) The corrective action taken the other residents that have the other residents that have the other resident practice is all residents have the potential to be affected by the same deficient practice is all residents have the potential to 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 to completed a visual inspection the oxygen room door.  3.) The measures that have the put into place to ensure that the deficient practice does not recan inspection tool was created and placed in the TELs system the Maintenance Director to complete visual inspection of fire doors within the facility monthly.  4.) The corrective action taken monitor to ensure the deficient practice will not recur is that a	y the ative en for the circe. sel, rector of the circ is dim for all	10/27/2024	
(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.				Quality Assurance tool has be designed and implemented fo Maintenance Director or desig to complete monthly for 6 mo	r the gnee			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/09/2024	
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER			2819 N	ADDRESS, CITY, STATE, ZIP COD IORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NOY MUST BE PRECEDED BY FULL  DE LOC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	(4) No parts are mi (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door con from the full open p (7) If a coordinator closes before the ac (8) Latching hardw door when it is in ti (9) Auxiliary hardw prohibit operation a frame. (10) No field modif have been performe (11) Gasketing and inspected to verify This deficient pract residents, as well as Findings include:  Based on record re a.m. and 2:15 p.m. 5:30 p.m. with the Maintenance Direct unable to provide de inspection of the or door assembly. Ba record review, the b was no documentat the oxygen transfill available to review during a tour of the 4:15 p.m., there was fire door assembly  This finding was re-	s do not exceed clearances 6.3.1.7. g device is operational; that is, appletely closes when operated position. is installed, the inactive leaf etive leaf. are operates and secures the	TAG	then quarterly for 2 quarters. results of these audits will be discussed at the monthly facil QAPI meeting monthly for 6 months and then quarterly for quarters. Frequency and during freviews will be increased a needed if any areas of noncompliance are identified during the auditing process.	ity 2 ation

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 01 COMPLI  B. WING 10/09/2			LETED		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Ε	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 01	Testing Based on observati interview; the facil documentation was nonhospital-grade oresident room local NFPA 99, Health Of Section 6.3.4.1.3 st hospital-grade, at plocations where de anesthesia is admir intervals not excee Section 6.3.3.2, Re Rooms requires the receptacle shall be The continuity of the electrical receptacl polarity of the hot a each electrical receptacl receptacles) shall be ounces). This defice residents.  Findings include:  Based on record re a.m. and 2:15 p.m. 5:30 p.m. with the Maintenance Direct documentation ava room receptacle tes receptacles for the	on, record review and ity failed to ensure complete available for all electrical receptacles in all cions tested at least annually. Care Facilities Code 2012 Edition, actes receptacles not listed as ratient bed locations and in ep sedation or general histered, shall be tested at ding 12 months. Additionally, ceptacle Testing in Patient Care exphysical integrity of each confirmed by visual inspection. The grounding circuit in each eshall be verified. Correct and neutral connections in explace shall be confirmed; and the grounding blade of each explained (except locking-type explained to the standard again between 4:15 p.m. and Executive Director and tor present, there was no ilable of an annual resident at for non hospital-grade past 12 month period. Based time of record review, the	K 0	914	K-914 1.) The corrective action take those residents found to have been affected by the deficie practice is the Maintenance Director completed electrical receptacle testing in all residence on the complete outcomes. 2.) The corrective action take the other residents that have potential to be affected by the same deficient practice is all residents have the potential affected by this deficient practice will deficient practice on NFPA 99, Head Care Facilities Code 2012 Educated on NF	l dent nces ken for e the ne l to be actice. vas lth addition, letted in all e been e the ecur is ed em for cle ken to ent e actice.	10/27/2024

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STATEMENT OF DEFICIENCIES X1) PROVAND PLAN OF CORRECTION IDENTIFI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  10/09/2024		
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
K 0918 SS=F Bldg. 01	Maintenance Direct resident rooms were receptacles as far as exceptions from what replaced. The Execution find documentatesting per NFPA 9 requirements was not information within Based on observations, and during a tour of Maintenance Direct Assistant, there were receptacles in each This finding was reduced by the Director and Maintenance States of the Maintena	tor said electrical receptacles in e not hospital-grade she knew with a few nen a receptacle had to be entive Director said she could tion to show that annual 9, Receptacle Testing net with all pertinent the past 12 month period. Ons between 2:15 p.m. and 4:15 of the facility with the tor and Maintenance re at least four to six electrical resident room.  Viewed with the Executive enance Director during the exit		designed and implemented for Maintenance Director or design to complete monthly for 6 monthen quarterly for 2 quarters. results of these audits will be discussed at the monthly facilit QAPI meeting monthly for 6 months and then quarterly for quarters. Frequency and dura of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	the nee of the the ty 2 of the tion is		
	facility failed to ma of monthly generate generator during 2 of 6.4.4.1.1.4(a) of 20 testing of the gener electrical system to 110, the Standard for Powers Systems, C NFPA 99 requires a performance, exerc generator to be regular for inspection by the jurisdiction. Chapt requires batteries for	review and interview, the sintain a complete written record or load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the alarly maintained and available e authority having er 6-4.4.1.3 of 2012 NFPA 99 or on-site generators shall be redance with NFPA 110, 2010	K 0918	K-918  1.) The corrective action taker those residents found to have been affected by the deficient practice is the facility complete generator load testing and inspection/testing of the generators serving the emergency electric 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 the other residents that have the potential to be affected by the	ator cal er me f		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>01</u>			COMPLETED	
155348		B. W	B. WING 10/0			/2024	
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD		
					ORTH ST JOSEPH AVE		
PARKVIE	EW CARE CENTER	2		EVANS	VILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		or Emergency and Standby			same deficient practice is all		
		3.7 requires storage batteries,			residents have the potential to	be	
		e levels or battery voltage,			affected by this alleged deficie	∍nt	
		with systems shall be			practice. The Maintenance		
		nd maintained in full			Director was educated on 201		
	_	anufacturer's specifications.			NFPA 99 Chapter 6.4.4.1.1.4(	a),	
		tive batteries shall be repaired			NFPA 110, the Standard for		
	_	ately upon discovery of			Emergency and Standby Pow	ers	
	_	5.4.2 of NFPA 99 requires a			System, Chapter 8., Chapter		
		spection, performance,			6-4.4.1.3 of 2012 NFPA 99, N	FPA	
		and repairs shall be regularly		110, 2010 Edition, Standard for		or	
		ilable for inspection by the		Emergency and Standby Power			
		risdiction. This deficient		Systems 8.3.7 and 8.3.7.2, and		ıd	
	practice could affect	et all residents, staff and		Chapter 6.5.4.2 of NFPA. The		9	
	visitors.			Maintenance Director completed a			
					generator load test and		
	Findings include:			inspection/testing of the			
					emergency generator.		
		the generator inspection and			3.) The measures that have been		
		0/09/24 between 9:15 a.m. and			put into place to ensure that the		
	-	between 4:15 p.m. and 5:30			deficient practice does not recur is		
	_	ative Director and Maintenance			the monthly inspection schedule		
	•	ere was no monthly generator			for the load bank testing of the		
		ation available for August and			generator and the weekly		
	*	for the emergency generator.			inspection/testing for the gene		
		at the time of record review,		was placed into the TELs system			
		ctor confirmed there was no		for the Maintenance Director to			
		ocumentation available for		complete timely. An inspection			
	August and Septem	ber of 2024.		tool was created for the			
					Maintenance Director to comp		
	_	viewed with the Executive			monthly load bank testing and		
		enance Director during the exit			weekly inspection/testing of th	ie	
	conference.				generator.		
					4.) The corrective action take		
	3.1-19(b)				monitor to ensure the deficien	t	
					practice will not recur is that the		
		review and interview, the			Quality Assurance inspection		
	_	sure a written record of weekly			and TELs maintenance schedule		
	_	1 generator was maintained			for monthly load bank testing	will	
	for 5 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA				be monitored monthly for 6		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         A. BUILDING       01       COMPLETED         B. WING       10/09/202			ETED			
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720					
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF POP requires batterie be maintained in act Edition, Standard for Power Systems. 8.1 including electrolyth used in connection inspected weekly accompliance with marked to replaced immediate defects. Chapter 6. written record of in exercising period, a maintained and avaintained and again practice could affect visitors.  Findings include:  Based on review of testing reports on 1 2:15 p.m. and again p.m. with the Execut Director present, the available to show the inspected/tested we October 4, 2024. Brecord review, the I there was no weekly documentation avaintained and october 4, 2024. This finding was resulted to the property of the	STATEMENT OF DEFICIENCIE CCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION IS for on-site generators shall cordance with NFPA 110, 2010 or Emergency and Standby 3.7 requires storage batteries, the levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. The batteries shall be repaired attely upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly illable for inspection by the risdiction. This deficient at all residents, staff and The generator inspection and 10/09/24 between 9:15 a.m. and 10 between 4:15 p.m. and 5:30 11 attive Director and Maintenance are was no documentation are emergency generator was early between August 23 and tased on interview at the time of Executive Director confirmed by generator inspection/testing lable for review between 10 ber 4, 2024.  Wiewed with the Executive 11 enamed to the exit		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  months by the Maintenance Director or desginee. The Qua Assurance inspection tool and TELs maintenance schedule for the weekly inspection/testing for the generator will be completed weekly for 4 weeks, monthly for months by the Maintenance Director or designee. The res of these reviews will be discus at the monthly facility QAPI meeting monthly for 6 months. Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.	ality or or d or 5 ults sed	(X5) COMPLETION DATE	

Event ID: 4N0S21 Facility ID: 000239 If continuation sheet Page 24 of 26

10/29/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/09/2024 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE PARKVIEW CARE CENTER **EVANSVILLE, IN 47720** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0920 **NFPA 101** SS=E Electrical Equipment - Power Cords and Bldg. 01 Extens Based on observation and interview, the facility K 0920 K-920 10/27/2024 failed to ensure power strips and extension cords 1.) The corrective action taken for were not used as a substitute for fixed wiring in 1 those residents found to have of over 50 resident rooms and 4 staff rooms. LSC been affected by the deficient 19.5.1 requires utilities to comply with Section 9.1. practice is the power strip and/or LSC 9.1.2 requires electrical wiring and equipment extension cord was removed from to comply with NFPA 70, National Electrical Code, the Staff Development Office, Holly 2011 Edition. NFPA 70, Article 400.8 requires that, Unit Nurse's Station, Infectious unless specifically permitted, flexible cords and Disease Office, room 215 and cables shall not be used as a substitute for fixed Cherry Lane Unit Med Room. No wiring of a structure. This deficient practice could resident experienced a negative affect least two residents and multi staff. outcome. 2.) The corrective action taken for Findings include: the other residents that have the potential to be affected by the Based on observations on 10/09/24 between 2:15 same deficient practice is all p.m. and 4:15 p.m. during a tour of the facility with residents have the potential to be the Maintenance Director and Maintenance affected by this alleged deficient Assistant, the following was noted: practice. The Maintenance a. The Staff Development Office had a refrigerator Director was educated LSC and microwave oven plugged into a power strip. 19.5.1, LSC 9.1.2, NFPA 70, b. The Holly Unit Nurse's Station had a window National Electrical Code, 2011 AC unit plugged into a power strip. Edition. The Maintenance Director c. The Infectious Disease Office had a microwave completed a visual inspection of oven plugged into an extension cord. facility offices and resident rooms d. Room 215 had a refrigerator plugged into a to ensure any power strip used for power strip. PCREE meet UL 1363A or UL e. The Cherry Lane Unit Med Room had a 60601-1 and non-PCREE meet UL refrigerator plugged into a multi plugged 1363. extension cord. 3.) The measures that have been This was acknowledged by the Maintenance put into place to ensure that the Director and Maintenance Assistant at the time of deficient practice does not recur is

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conference.

each observation.

This finding was reviewed with the Executive

Director and Maintenance Director during the exit

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an inspection tool was created for the Maintenance Director to

inspection of all facility offices and

resident rooms to ensure power

complete monthly for visual

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  10/09/2024		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW CARE CENTER			•	2819 N	ADDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE VILLE, IN 47720			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  3.1-19(b)		ID PREFIX TAG  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)  strips and extension cords being used as a substitute fixed wiring  4.) The corrective action is monitor to ensure the defi practice will not recur is the Quality Assurance inspect and the TELs maintenance schedule for monthly load testing will be monitored in for 6 months by the Mainte Director or designee. The maintenance schedule for			en to  en to  he tool  hk thly nce	to  sol  y  e  so	
					weekly inspection/testing for t generator will be completed weekly for 4 weeks, monthly f months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 months. Freque and duration of reviews will be increased as needed if any ar of noncompliance are identified during the auditing process.	for 5 ne ency e eeas		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4N0S21 Facility ID: 000239 If continuation sheet Page 26 of 26