| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155489 | A. BUILDING -- B. WING | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| PARKER HEALTH CARE & REHABILITATION CENTER | 359 RANDOLPH ST PARKER CITY, IN 47368 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/22/24<br><br>Facility Number: 000419<br>Provider Number: 155489<br>AIM Number: 100273190<br><br>At this Emergency Preparedness survey, Parker Health Care and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 89 certified beds. At the time of the survey, the census was 61.<br><br>Quality Review completed on 08/27/24 | E 0000 | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.<br>Please accept this Plan of Correction as credible Allegations of Compliance date as of 9/07/2024. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 08/22/24<br><br>Facility Number: 000419<br>Provider Number: 155489<br>AIM Number: 100273190<br><br>At this Life Safety Code survey, Parker Health | K 0000 | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.<br>Please accept this Plan of | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Angela Durr | HFA | 09/06/2024 |

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| | Care & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has one hall which is assisted living, the presence of a 2 hour rated occupancy separation wall could not be verified and the double door set did not latch, therefore the entire facility was surveyed. The facility has a capacity of 89 and had a census of 61 at the time of this visit.<br><br>All areas providing facility services were sprinkled and all areas where residents have customary access were sprinkled.<br><br>Quality Review completed on 08/27/24 | | Correction as credible Allegations of Compliance date as of 9/07/2024. | |
| K 0226 SS=E Bldg. 01 | NFPA 101<br>Horizontal Exits<br><br>Based on observation and interview, the facility failed to ensure 1 of 2 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door | K 0226 | **What corrective actions will be accomplished for those residents found to be affected by the deficient practice.**<br>New Hardware and latch has been ordered to repair fire- door.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 09/07/2024 |

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| | to close and latch each time it is opened. This deficient could affect 10 residents in 2 smoke compartments when occupied.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 p.m., the rated fire door set in the fire wall near the Administrators Office, when tested failed to latch. The MD stated that the hardware was busted and could not be repaired, a new latching door with new hardware had been ordered.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | **action taken:**<br>10 residents in 2 smoke compartments when occupied could be affected.<br>Corrective actions will be monitored to ensure the deficient practice will not re-occur.<br>All fire doors will be inspected at least 1 x monthly for 6 months for proper closure compliance. All findings will be s recorded in the preventative maintenance and signed off by administrator/Designee. Any doors found to not latch correctly will be repaired immediately and brought to quarterly QAPI/ or as needed to ensure compliance.<br>Date of systematic changes to ensure compliance will be effective _9-7-2024_.<br>(Exhibit A) | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 2 residents, as well as staff and visitors in 1 smoke compartment.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 p.m., Resident Room #108, greater than 50 square feet contained a number of combustible items, | K 0321 | **What corrective action will be accomplished for those residents found to be affected by the deficient Practice:**<br>All combustible items have been removed from #108 and no longer contain combustible items no longer requiring a self-closing fixture.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and corrective action taken.** | 09/07/2024 |

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| | such as, paper, plastic, and over 20 cardboard boxes. The corridor door to this room did not self-close and latch into the door frame. The MD stated that IT was using the room to store supplies.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | This deficient practice could affect 2 residents, as well as staff and visitors in 1 smoke compartment.<br><br>**What measures will be put into place and what systematic changes will be made to ensure compliance:**<br>Nine resident rooms in Park-Place will be monitored for Storage of combustible material 2x monthly for 6 months to assure compliance. All doors will be signed off by Administrator/Designee<br>Any findings will be corrected immediately and brough to quarterly QAPI meeting or as needed to ensure compliance.<br>Date of systematic changes to ensure compliance will be effective:__9-7-2024_____<br>____<br>(see Exhibit B & C) | |
| K 0324<br>SS=E<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>Based on observation and interview, the facility failed to maintain equipment protected by the kitchen hood extinguishing system in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. | K 0324 | **What corrective action will be accomplished for those residents found be to be affected by this deficient Practice:**<br>Wheel stabilizers for kitchen equipment has been installed to ensure that appliance was returned to an approved design location after being moved for Maintenance or Cleaning.<br>This deficient practice affected | 09/07/2024 |

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| | Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual.<br>Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location.<br><br>The deficient practice affected residents and staff in one (1) of six (6) smoke compartments.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 p.m., in the kitchen a wheeled range was located on the cooking line under the hood and was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | residents in 1 of 6 smoke compartments.<br>**What measures will be put into place and what systematic changes will be made to ensure compliance:**<br>Maintenance will inspect proper placement of Kitchen appliance 1x monthly for 6 months. Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance.<br>Date of Systematic Changes to ensure compliance will be effective:<br>__9-7-2024_____<br>Exhibit D &E. | |
| K 0712<br>SS=C<br>Bldg. 01 | NFPA 101<br>Fire Drills<br><br>Based on record review and interview, the facility | K 0712 | What corrective action will be | 09/07/2024 |

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| | failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility.<br><br>Findings include:<br><br>Based on records review and interview with the Maintenance Director (MD) on 08/22/24 between 9:30 a.m. and 11:45 a.m. 8 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | accomplished for those residents found be to be affected by this deficient Practice:<br>The facility will continue to monitor that all fire drills are conducted quarterly on unexpected days and at unexpected times under varying conditions.<br>This deficient practice could affect all residents, staff and visitors in the facility.<br>**What measures will be put into place and what systematic changes will be made to ensure compliance:**<br>Maintenance Director/Designee will continue to conduct fire drills quarterly on unexpected days and unexpected times under various conditions. Documentation of Fire Drills will be monitored 1 time monthly for 12 months by the Maintenance Director and approved by admin/designee to ensure compliance. Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance.<br>Date of Systematic Changes to ensure compliance will be :_____9-7-2024_____<br>Exhibit F and G | |
| K 0761<br>SS=F<br>Bldg. 01 | NFPA 101<br>Maintenance, Inspection & Testing - Doors<br><br>Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 3 fire door | K 0761 | **What corrective action will be accomplished for those residents found be to be** | 09/07/2024 |

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| | assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf. | | **affected by this deficient Practice:**<br>Facility Maintenance Director/Designee will continue to complete an annual fire inspection and log on an annual basis.<br>This deficient practice can affect all residents in the facility.<br>Annual door inspections will be completed by Maintenance/Designee 1 x yearly.<br>Inspection to be approved and signed off per admin or designee.<br>Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance.<br><br>Date of Systematic Changes to ensure compliance will be :_____9-7-2024_____<br>___<br>Exhibit H | |

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| | (8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on records review and interview with the Maintenance Director (MD) on 08/22/24 between 9:30 a.m. and 11:45 a.m. no documentation of an annual inspection for the fire door assemblies was available for review. Based on observation during the tour there are (3) one-and-a-half-hour fire door assembly (two in the corridors and one at the Oxygen transfilling room). Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year. Documentation was available for regular weekly/monthly door inspections, but not for an annual Fire Door inspection. A telephone call to a regional support representative indicated the belief that the inspections were done, however no documentation was provided.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | | |
| K 0781 SS=E | NFPA 101<br>Portable Space Heaters | | | |

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| Bldg. 01 | Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 8 staff and visitors in Conference Room.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 p.m., a portable space heater was in use in the Conference Room. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was being used and stated that the facility policy was that no portable space heaters were allowed.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | K 0781 | **What corrective action will be accomplished for those residents found be to be affected by this deficient Practice:**<br>Facility Maintenance Director/Designee will continue to monitor facility for the use of portable space heaters. Space heater has been removed from conference room area.<br>This deficient practice could affect up to 8 staff or visitors in the conference room.<br>Monthly inspections of offices/conference room will be conducted 1 x monthly for 6 months to ensure compliance.<br>Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance.<br>Date of Systematic monitoring to ensure compliance will be:___9-7-2024_____<br>_____<br>Exhibit I & J | 09/07/2024 |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.<br>NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 8 staff in | K 0920 | **What corrective action will be accomplished for those residents found be to be affected by this deficient Practice:**<br>Facility Maintenance Director/Designee will continue to monitor the facility for the use of | 09/07/2024 |

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| | the conference room.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 p.m., in the Conference Room a power strip was being used to power a portable space heater (high power draw equipment).<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | extension cords in office areas. Extension Cord has been removed from the conference room area. This deficient practice could affect up to 8 staff or visitors in the conference room. Monthly inspections of offices/conference room will be conducted 1 x monthly for 6 months to ensure compliance. Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance. Date of Systematic monitoring to ensure compliance will be: _____9-7-2024_____<br>_____<br>Exhibit K&L | |
| K 0927 SS=E Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br><br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 12 residents in one smoke compartment.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 08/22/24 between 11:45 a.m. and 1:30 | K 0927 | **What corrective action will be accomplished for those residents found be to be affected by this deficient Practice:**<br>Facility Maintenance Director/Designee will continue to monitor areas where oxygen is stored to ensure vents are in proper working order. A new operatable vent has been installed in the Oxygen storage area. This deficient practice could affect up to 12 residents in one smoke compartment. Monthly inspections of Oxygen room will be conducted 1 x | 09/07/2024 |

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| | p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was one vent, but the vent did not appear to be working. Based on interview at the time of observation, the MD stated the oxygen room vent did not appear to be operating.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.<br><br>3.1-19(b) | | monthly for 6 months to ensure compliance. Any findings will be corrected immediately and brough to a quarterly QAPI meeting or as needed to ensure compliance. Date of Systematic monitoring to ensure compliance will be:_____9-7-2024_____<br>_<br>Exhibit M & N | |