STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155489	A. BUILDING 01 B. WING	09/26/2024

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

(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 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/22/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/26/24 Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190 At this PSR to the Life Safety Code survey, Parker Health 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. 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. All areas providing facility services were sprinkled and all areas where residents have customary	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. Please accept this Plan of Correction as credible Allegations of Compliance date as of 10/14/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Durr	HFA	10/17/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	access were sprinkled. Quality Review completed on 09/30/24			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits 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 to close and latch each time it is opened. This deficient could affect 10 residents in 2 smoke compartments when occupied. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 09/26/24 between 9:20 a.m. and 10:15 a.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. The MD stated that when they attempted to repair the hardware, it all fell apart on the floor, so the decision was made to order brand new doors with hardware. The cost took a while to nail down. The surveyor suggested to the MD that they consider a requesting a waiver if they deemed it necessary. This finding was acknowledged by the Maintenance Director at the time of discovery and	K 0226	**What corrective actions will be accomplished for those residents found to be affected by the deficient practice.** New Door has been ordered effective 10-3-2024 after original parts that were placed failed to assure proper closure. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action taken:** 10 residents in 2 smoke compartments when occupied could be affected. Corrective actions will be monitored to ensure the deficient practice will not re-occur. Fire doors by Admin office will be tested 1 x weekly to ensure operation of door to ensure compliance until new doors arrive and installed. All findings will be s recorded in the preventative maintenance and signed off by administrator/Designee. Any findings will be reported immediately and brought to quarterly QAPI/ or as needed to ensure compliance. Date of systematic changes to	12/31/2024

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	again during the exit conference with the Maintenance Director present. This deficient practice was cited on 08/22/24. The facility failed to implement proper corrective action. 3.1-19(b)		ensure compliance will be effective -2024. Waiver applied for 10-10-2024 to allow for extended time for products/delivery and installation.	