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	01/22/2025

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	An investigation of Complaint Number IN00451410 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number IN00451410 was substantiated. A Federal/State deficiency related to the allegation was cited at K226. Survey Date: 01/22/25 Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190 At this Complaint 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 a capacity of 89 and had a census of 62 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 01/31/2025 We respectfully ask for consideration of paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Durr	HFA	01/31/2025

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 conducted on 01/23/25			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets were arranged to minimize air leakage. LSC 7.2.4.3.9 requires all fire door assemblies in horizontal exit shall be designed and installed to minimize air leakage. This deficient could affect 15 residents. Findings include: Based on observations during a tour of the facility with the Administrator on 01/22/25 between 1:00 p.m. and 1:40 p.m., the fire door set which was recently installed had at least a 1/2-inch gap along the center where the doors came together in the closed position. This condition did not minimize air leakage. Based on interview at the time of observation, the Administrator agreed that the doors when closed, had a ½ inch gap and confirmed these fire doors were located within a horizontal exit. This finding was reviewed with the Administrator at the exit conference. This citation is related to complaint IN00451410. 3.1-19(b)	K 0226	What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Correction of Seal installation resulting in 1/8 inch gap completed 1-31-25 (Exhibit A) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action taken: 15 residents 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 for 4 weeks then 1 x monthly for 5 months and ongoing during monthly routine checks to ensure compliance . (Exhibit B) All findings will be 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 ensure compliance will be effective	01/31/2025

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