STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING -- B. WING	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/19/22 Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270 At this Emergency Preparedness survey, Signature Healthcare at Parkwood was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 106 certified beds. At the time of the survey, the census was 69. Quality Review completed on 12/22/22	E 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility respectfully requests Paper Compliance, documents attached.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/19/22 Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270 At this Life Safety Code survey, Signature	K 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Peter	E.D.	01/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Healthcare at Parkwood 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors hard wired smoke detectors in ten resident rooms on Maplewood and battery powered smoke detectors in all other resident sleeping rooms. The facility has a capacity of 106 and had a census of 69 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/22/22		Facility respectfully requests Paper Compliance, documents attached.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets located within a horizontal exit was 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	K 0226	1. Fire door set by Social Service Director office was adjusted and closed properly on 12/19/22. 2. 26 residents had the potential to be affected. Other fire door sets were audited and working appropriately.	01/03/2023

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	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 as many as 24 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator and the Plant Operations Manager (P.O.M.) on 12/19/22 at 11:37 a.m., the fire door set by the Social Service Directors office failed to fully close and latch when tested on three separate occasions. Based on interview at the time of observation, the P.O.M. confirmed this fire door set by the Social Service Directors office did not fully close and latch leaving a 1-inch gap and stated that he would adjust the doors as soon as he was able to do so. This finding was reviewed with the Administrator at the exit conference on 12/19/22 at 1:45 p.m. 3.1-19(b)		3. Director of Plant Operations and Administrator were re-educated on proper closure of Horizontal Exits by Regional Director of Plant Operations. 4. Director of Plant Operations and/or Administrator will audit doors for proper closure 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Results will be forward to Quality Assurance Committee monthly for 4 months or until compliance achieved.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to install exit signage in 1 of 1 corridor in the Rosewood common area in accordance with LSC	K 0293	1. "Not an Exit" sign was placed in the Redwood Common Area on the door on 1/06/22.	01/06/2023

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	7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect as many as 26 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator and the Plant Operations Manager (P.O.M.) on 12/19/22 at 11:37 a.m., the glass Exit doors in the Redwood common area were not marked as a facility Exit or Not an Exit. Based on interview at the time of observation, the P.O.M. acknowledged the aforementioned condition and confirmed that the path of egress was not obvious and added that he would have the appropriate signage ordered and installed as soon as possible. This finding was reviewed with the Administrator at the exit conference on 12/19/22 at 1:45 p.m. 3.1-19(b)		2. 26 residents had the potential to be affected. Other exit doors were audited to ensure proper signage was in place. 3. Director of Plant Operations and Administrator were re-educated on proper signage for facility exit doors by Regional Director of Plant Operations. 4. Director of Plant Operations and/or Administrator will audit exit doors for proper signage 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Results will be forward to Quality Assurance Committee monthly for 4 months or until compliance achieved.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an			

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	atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 11 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect as many as 26 residents, 4 staff, and 2 visitors between the two compartments. Findings include: Based on observations made during a tour of the facility with the Administrator and the Plant Operations Manager (P.O.M.) on 12/19/22 at 12:34 p.m., the barrier door set nearest to the Redwood nurses' station had a hole drilled through it for the passage of six data cables. This area had been sealed off with calk, but the calk was old and had dried out falling out of the hole it had previously sealed off. This left approximately 2 inches of annular space around the data cables passing through the smoke barrier. Based on interview at the time of observation, the P.O.M. acknowledged the aforementioned condition and stated that he would seal the penetration as soon as he had time to do so. This finding was reviewed with the Administrator at the exit conference on 12/19/22 at 1:45 p.m.	K 0372	1. Barrier door set hole penetration nearest to Redwood Nurse Station was sealed with proper caulk on 12/19/22. 2. 26 residents had the potential to be affected. Other 10 smoke barrier walls were audited to ensure compliance. 3. Director of Plant Operations and Administrator were re-educated on Smoke Barrier walls being protected to maintain the smoke resistance. 4. Director of Plant Operations and/or Administrator will audit Smoke Barrier walls for penetrations 1 time weekly for 4 weeks, then monthly thereafter. Results will be forward to Quality Assurance Committee monthly for 4 months or until compliance achieved.	01/03/2023

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	3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 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, Health Care Facilities, 2012 edition, Section 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 as many as 26 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator and the Plant Operations Manager (P.O.M.) on 12/19/22 at 11:40 a.m., the oxygen storage/transfilling room had six large liquid oxygen tanks. There was a mechanically ventilated exhaust fan in the ceiling of this room, however, it was not working at the	K 0927	1. Mechanically ventilated exhaust fan replaced on 12/20/22 in Oxygen Storage room. 2. 26 residents had the potential to be affected. No other Oxygen Storage rooms are in the facility. 3. Director of Plant Operations and Administrator were re-educated on having proper functioning Mechanical Ventilation in rooms where oxygen transfilling takes place by Regional Director of Plant Operations. 4. Director of Plant Operations and/or Administrator will audit to ensure the Mechanically Ventilated Exhaust Fan is functioning properly 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly	01/03/2023

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	time of observation. This was tested by holding a small piece of paper up to the vent to test it for suction. Based on an interview at the time of the observation, the P.O.M. stated that he would replace the existing fan as soon as he was able to do so. This finding was reviewed with the Administrator at the exit conference on 12/19/22 at 1:45 p.m. 3.1-19(b)		thereafter. Results will be forward to Quality Assurance Committee monthly for 4 months or until compliance achieved.	