CE. TEROTOR	THE CONTENTS	SERVICES				21.0.0,000	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			r í	PLE CONSTRUCTION	r /	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDI	A. BUILDING		COMPLETED	
155378		155378	B. WING		12/19/	/2022	
		1	ÇT	REET ADDRESS, CITY, STATE, ZIP (COD		
NAME OF F	PROVIDER OR SUPPLIE	₹		01 N GRANT ST	<i></i>		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		EBANON, IN 46052			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREI		SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA			DATE	
E 0000							
Bldg							
g.	An Emergency Pre	paredness Survey was	E 0000	Preparation and/or ex	ecution of		
		ndiana Department of Health in	1 2 0000	this plan of correction			
	accordance with 42	-		does not constitute an	-		
		6110 1001,01		of an agreement by th			
	Survey Date: 12/19	9/22		the facts alleged or co	nclusions		
	Facility Number C	000469		set forth in this statem			
	Facility Number: 0 Provider Number:			deficiencies. The plan			
	AIM Number: 100			correction and specific			
	Anvi Number: 100	290270		actions are prepared a executed in compliance			
	At this Emergency	Preparedness survey,		and Federal Laws.	e with State		
		re at Parkwood was found in		and Federal Laws.			
	_	mergency Preparedness		Facility respectfully re-	aucata		
	_	Medicare and Medicaid		Facility respectfully re	•		
		ders and Suppliers, 42 CFR		Paper Compliance, do	cuments		
	483.73	ders and Suppliers, 42 CFR		attached.			
	463.73						
	The facility has 106	6 certified beds. At the time of					
	the survey, the cens						
	the survey, the cens	sus was 69.					
	Ovality Daview as	mpleted on 12/22/22					
	Quality Review cor	inpleted on 12/22/22					
K 0000							
Bldg. 01							
Diag. 01	A Life Safety Code	Recertification and State	K 0000	Preparation and/or ex	ecution of		
	1	was conducted by the Indiana	K 0000	this plan of correction			
	1	lth in accordance with 42 CFR		does not constitute an	-		
	483.90(a).	im in accordance with 42 CFR		of an agreement by th			
	703.70(a).			the facts alleged or co	•		
	Survey Date: 12/19	2/22		set forth in this statem			
	Survey Date. 12/15	// 44		deficiencies. The plan			
	Facility Number: 0	000468		· · · · · · · · · · · · · · · · · · ·			
	Provider Number:			correction and specific			
				actions are prepared a			
	AIM Number: 100	230270		executed in compliand	e with state		
	At this I ifo Safata	Code survey, Signature		and Federal Laws.			
	At this Life Safety	Code survey, signature					
LADODATOD	V DIDECTORIC OR PRO	VIDED CHIDDI IED DEDDECENTATUTEC	UCNATURE	TITLE		(VA) DATE	
LABORATOR	AT DIKECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	BIGNATURE	TITLE		(X6) DATE	

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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E.D.

Chris Peter

01/06/2023

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
155378		B. W	B. WING 12/19/2022					
			<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				GRANT ST			
SIGNATI	JRE HEALTHCARE	AT BARKWOOD			ON, IN 46052			
SIGNATO	JNE HEALTHCANE	AT FARRWOOD		LEDAN	ON, IN 40032			
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		wood was found not in			Facility respectfully requests			
	•	equirements for Participation in		Paper Compliance, do		S		
		, 42 CFR Subpart 483.90(a),			attached.			
		re and the 2012 edition of the						
		ection Association (NFPA) 101,						
		LSC), Chapter 19, Existing						
	Health Care Occupa	ancies and 410 IAC 16.2.						
	Th: (C '1	in						
		ity was determined to be of						
		ruction and was fully						
	-	cility has a fire alarm system on in the corridors, spaces						
		rs hard wired smoke detectors						
	-	as on Maplewood and battery						
		ectors in all other resident						
	-	e facility has a capacity of 106						
		69 at the time of this survey.						
	and had a census of	of 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 con	npleted on 12/22/22						
K 0226	NFPA 101							
SS=E	Horizontal Exits							
Bldg. 01	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	7, or 19.2.2.5.1 through						
	19.2.2.5.4.							
	18.2.2.5, 19.2.2.5							
		on and interview, the facility	K 0	226	1. Fire door set by Social		01/03/2023	
		f 3 fire door sets located within			Service Director office was			
		s arranged to automatically			adjusted and closed properly	on		
		C section 7.2.4.3.10 requires all			12/19/22.			
		s in horizontal exits shall be			2. 26 residents had the	.:		
		matic closing. In addition			potential to be affected. Other	riire		
		lard for Fire Doors and Other s. section 6.1.4.2.1 states			door sets were audited and			
1	L COCHING PROJECTIVE	S SECTION OFF 4 / 1 STATES			i working appropriately		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155378		B. WING	ì		12/19/	2022	
				TDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
CIONATI					GRANT ST		
SIGNATO	JRE HEALTHCARE	ATPARKWOOD		EBAN	ON, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	ΓAG	DEFICIENCY)	16	DATE
	self-closing doors sl	hall swing easily and freely			Director of Plant Operat	ions	
	_	ed with a closing device to			and Administrator were		
		ose and latch each time it is			re-educated on proper closure	of	
		ent could affect as many as 24			Horizontal Exits by Regional		
	residents, 4 staff and	-			Director of Plant Operations.		
					Director of Plant Operat	ions	
	Findings include:				and/or Administrator will audit		
	i manigs merade.				doors for proper closure 3 time		
	Based on observation	ons made during a tour of the			weekly for 4 weeks, then week		
		ministrator and the Plant			for 4 weeks, then monthly	чу	
	-	r (P.O.M.) on 12/19/22 at 11:37			thereafter. Results will be forv	ward	
		et by the Social Service			to Quality Assurance Committ		
	· ·	ed to fully close and latch			monthly for 4 months or until	56	
		e separate occasions. Based			compliance achieved.		
		time of observation, the P.O.M.			compliance achieved.		
		door set by the Social Service					
		not fully close and latch					
		and stated that he would					
	adjust the doors as s	soon as he was able to do so.					
	This finding was ra	viewed with the Administrator					
	This finding was reviewed with the Administrator at the exit conference on 12/19/22 at 1:45 p.m.						
	at the exit conference	ce on 12/19/22 at 1:43 p.m.					
	2.1.10(%)						
	3.1-19(b)						
K 0293	NFPA 101						
SS=E							
Bldg. 01	Exit Signage						
Blug. 01	Exit Signage						
	2012 EXISTING	al ainma ana diambaya din					
		al signs are displayed in					
		7.10 with continuous					
		erved by the emergency					
	lighting system.						
	19.2.10.1	a atam a siatio -					
	(Indicate N/A in or	-					
	•	less than 30 occupants					
		exit travel is obvious.)					04/06/2222
		view and interview; the facility	K 029	3	1. "Not an Exit" sign was		01/06/2023
		signage in 1 of 1 corridor in the			placed in the Redwood Comm	on	
	Rosewood common	area in accordance with LSC			Area on the door on 1/06/22.		

		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED			
		155378	B. W	ING		12/19/	2022		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			•	STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON, IN 46052					
(V4) ID	CLIMALA DAY CTA TEMENT OF DEFICIENCIE				Τ		(V5)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CV MUST BE PRECEDED BY EUL I		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
1710		1 exits, other than main exterior	+	1710	2. 26 residents had the		DATE		
		ously and clearly are			potential to be affected. Other	r exit			
		, shall be marked by an			doors were audited to ensure	CAIL			
		s readily visible from any			proper signage was in place.				
		ess. LSC 7.10.1.2.2 states			3. Director of Plant Operat	ions			
		ents of the egress path within			and Administrator were				
	-	all be marked by approved exit			re-educated on proper signage	e for			
		igns where the continuation of			facility exit doors by Regional				
	the egress path is no	ot obvious. This deficient			Director of Plant Operations.				
	_	t as many as 26 residents, 4			4. Director of Plant Operat	ions			
	staff, and 2 visitors.				and/or Administrator will audit	exit			
					doors for proper signage 3 tim	ies			
	Findings include:				weekly for 4 weeks, then weel	kly			
					for 4 weeks, then monthly				
		ons made during a tour of the			thereafter. Results will be for				
	-	ministrator and the Plant			to Quality Assurance Committ	ee			
		r (P.O.M.) on 12/19/22 at 11:37			monthly for 4 months or until				
		doors in the Redwood			compliance achieved.				
		not marked as a facility Exit or							
		on interview at the time of							
		O.M. acknowledged the							
		dition and confirmed that the							
		not obvious and added that he							
	installed as soon as	ropriate signage ordered and							
	mstancu as soon as	possible.							
	This finding was re	viewed with the Administrator							
	-	ce on 12/19/22 at 1:45 p.m.							
	3.1-19(b)								
K 0372	NFPA 101								
SS=E		lding Spaces - Smoke							
Bldg. 01	Barrie								
		lding Spaces - Smoke							
	Barrier Construction	on							
	2012 EXISTING								
		all be constructed to a							
		ance rating per 8.5. Smoke							
	∣ barriers shall be p	ermitted to terminate at an							

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
	155378		B. WING		12/19/2022	
			CTDEET	Γ ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		N GRANT ST		
SIGNATURE HEALTHCARE AT PARKWOOD				NON, IN 46052		
SIGNATURE HEALTHCARE AT FARRWOOD			LLDA			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	atrium wall. Smok	e dampers are not required				
	in duct penetrations in fully ducted HVAC					
	systems where ar	n approved sprinkler system				
	is installed for sm	oke compartments adjacent				
	to the smoke barr					
	19.3.7.3, 8.6.7.1(•				
		chanical smoke control				
	system in REMAF					
		on and interview, the facility	K 0372	Barrier door set hole	01/03/2023	
		penetrations caused by the		penetration nearest to Redwo		
		l/or conduit through 1 of 11		Nurse Station was sealed with	h	
		s were protected to maintain the		proper caulk on 12/19/22.		
		f each smoke barrier. LSC		2. 26 residents had the		
		quires smoke barriers to be		potential to be affected. Other		
		rdance with LSC Section 8.5		smoke barrier walls were aud	ited	
		nimum ½ hour fire resistive		to ensure compliance.		
		nt practice could affect as many		Director of Plant Opera	tions	
		aff, and 2 visitors between the		and Administrator were		
	two compartments.			re-educated on Smoke Barrie		
	F' 1' ' 1 1			walls being protected to main	tain	
	Findings include:			the smoke resistance.	e l	
	D4			4. Director of Plant Opera		
		ons made during a tour of the		and/or Administrator will audit		
	1	ministrator and the Plant		Smoke Barrier walls for	4	
		er (P.O.M.) on 12/19/22 at 12:34 or set nearest to the Redwood		penetrations 1 time weekly fo		
	_	a hole drilled through it for the		weeks, then monthly thereafte		
		cables. This area had been		Results will be forward to Qua		
		t, but the calk was old and had		Assurance Committee month	ly IOI	
		t of the hole it had previously		4 months or until compliance achieved.		
		approximately 2 inches of		acilieved.		
		nd the data cables passing				
	_	barrier. Based on interview at				
	_	tion, the P.O.M. acknowledged				
		condition and stated that he				
		etration as soon as he had time				
	to do so.					
	This finding was re	viewed with the Administrator				
	_	ce on 12/19/22 at 1:45 p.m.				
	1	*	1		l l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155378	(X2) MULTIPLE A. BUILDING B. WING	<u></u>		RVEY TED 122		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			1001	STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON, IN 46052				
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen co containers over 50 under 11.5.2.3.1 (liquid oxygen con containers under conditions under 11.5.2.2 (NFPA 9) Based on observation failed to ensure 1 o oxygen transferring with properly work NFPA 99, Health C Section 11.5.2.3.1 (rooms to be mechan 9.3.7.5.3.1 requires a negative pressure This deficient pract residents, 4 staff, an Findings include: Based on observation facility with the Ad Operations Manage a.m., the oxygen ste large liquid oxygen mechanically ventil	on and interview, the facility of 1 oxygen storage room where takes place, was provided ing mechanical ventilation. Care Facilities, 2012 edition, (2) requires oxygen transfilling inically ventilated. Section mechanical exhaust to maintain in the space continuously. ice could affect as many as 26 and 2 visitors. ons made during a tour of the liministrator and the Plant or (P.O.M.) on 12/19/22 at 11:40 orage/transfilling room had six	K 0927	1. Mechanically vent exhaust fan replaced on in Oxygen Storage room 2. 26 residents had t potential to be affected. Oxygen Storage rooms facility. 3. Director of Plant C and Administrator were re-educated on having p functioning Mechanical vin rooms where oxygen takes place by Regional of Plant Operations. 4. Director of Plant C and/or Administrator will ensure the Mechanically Ventilated Exhaust Fan functioning properly 3 tir weekly for 4 weeks, then month	12/20/22 i. i. i. ihe No other are in the Operations oroper Ventilation transfilling Director Operations audit to is nes in weekly	01/03/2023		

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

PRINTED: 01/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378 NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON IN 46052			LETED		
SIGNATO	JKE HEALTHCARE	: AT PAKKWOOD	LEBANON, IN 46052				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	time of observation.	This was tested by holding a			thereafter. Results will be forv	vard	
	small piece of paper	r up to the vent to test it for			to Quality Assurance Committ	ee	
	suction. Based on a	n interview at the time of the			monthly for 4 months or until		
	observation, the P.C	O.M. stated that he would			compliance achieved.		
	replace the existing	fan as soon as he was able to			·		
	do so.						
	_	viewed with the Administrator are on 12/19/22 at 1:45 p.m.					

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