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	07/10/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/10/23 Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190 At this Emergency Preparedness survey, Parker Health Care and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 89 certified beds. At the time of the survey, the census was 55. Quality Review completed on 07/13/23	E 0000		
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Troy Shuck	Administrator	07/27/2023

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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	§491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 07/10/23 between 10:15 a.m. and 12:10 p.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the	E 0006	A facility all risk assessment has been completed. This assessment will be reviewed at least every two years. (See attachment). The Administrator will be responsible to make certain the assessment is completed. All residents have the potential to be affected. Completion date: July 21, 2023	07/21/2023

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	time of record review, the Administrator stated a risk assessment utilizing an all-hazards approach could not be found. This finding was acknowledged by the Maintenance Director and Administrator at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present.			
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: 07/10/23 Facility Number: 000419 Provider Number: 155489 AIM Number: 100273190 At this 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	K 0000		

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	155489	A. BUILDING 01 B. WING	07/10/2023

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	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 55 at the time of this visit. All areas providing facility services were sprinkled and all areas where residents have customary access were sprinkled. Quality Review completed on 07/13/23			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress throughout the facility were readily accessible for residents	K 0222	All residents have the potential to be affected. The exit doors near Therapy, near	07/21/2023

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	without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect everyone needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/10/23 between 12:10 p.m. and 3:30 p.m., throughout the facility, including the following exit doors were magnetically locked and could be opened by entering a four-digit code but the code was not posted, faded or required special knowledge to understand. A) Exit door near Therapy. B) Exit door near Resident Room # 1. C) Exit door near Resident Room # 37. D) Main Exit. This finding was acknowledged by the Maintenance Director and Administrator at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		resident room #1, near resident room #37, the main exit and all other exit doors were inspected to make certain the exit code is easily found and that the code does not require any special knowledge to understand. A code identification is in place on every code pad at each exit (see photo). The Maintenance Director will inspect all exit doors at least monthly to verify compliance. This will be documented in the TELS preventative maintenance system. Maintenance Director responsible. Completion date: July 21, 2023	
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.			

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	18.2.2.5, 19.2.2.5 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 40 residents in 2 smoke compartments when occupied. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/10/23 between 12:10 p.m. and 3:30 p.m., the rated fire door set in the fire wall (as evidenced by the presence of a corresponding parapet) near resident room # 43 when tested failed to latch into the frame due to one door having a plate installed over the latch. Based on interview at the time of observation, the Maintenance Director stated the fire door set was not latching into the frame likely because the plate. This finding was acknowledged by the Maintenance Director and Administrator at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0226	Thirty-five residents have the potential to be affected. The corridor door near resident room 43 has been serviced. The plate was removed permitting the door to latch properly. (See photo) All corridor doors will be checked at least monthly and documented in the TELS preventative maintenance system. Maintenance Director will be responsible. Completion date: July 21, 2023	07/21/2023
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting			

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	Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 4 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 3 staff in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/10/23 between 12:10 p.m. and 3:30 p.m., the battery-operated emergency light in the sprinkler riser room near the transfer switch failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, the Maintenance Director and stated battery operated lights in the facility are tested regularly and documentation provided during the record review indicated monthly testing, but acknowledged the aforementioned battery operated emergency light failed to function when its respective test button was pushed. This finding was acknowledged by the Maintenance Director and Administrator at the	K 0291	All residents have the potential to be affected. The battery in the emergency light in the sprinkler room had been inspected on June 16, 2023 and found to be working properly. Upon inspection on July 10, 2023, the battery was no longer working. The battery was replaced upon discovery. (See photos) All emergency lighting will continue to be inspected at least monthly. This will be documented in the TELS preventative maintenance system. Maintenance Director responsible. Date of Completion July 11, 2023	07/11/2023

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	time of discovery and again during the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the	K 0353	All residents have the potential to be affected. Although the four sprinkler gauges were working properly, these four gauges were replaced with updated gauges as required every five years. (See photos) The Maintenance Director will document in the TELS preventative maintenance system the due date when the gauges are due for replacement. Maintenance Director responsible.	07/11/2023

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	facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/10/23 between 12:10 p.m. and 3:30 p.m., the facility has supervised dry and wet sprinkler systems with gauges that were dated 2017. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Maintenance Director agreed the gauges were older than five years. This finding was acknowledged by the Maintenance Director and Administrator at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		Date of Completion July 11, 2023.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/10/23 between 12:10 p.m. and 3:30 p.m., the corridor door to resident room # 27 failed to close and latch positively into the door frame.	K 0363	Two residents have the potential to be affected. The doors to room #27 have been serviced and adjusted to insure proper latching. Doors are inspected monthly to evaluate proper functioning. This is documented in the TELS preventative maintenance system. Maintenance Director responsible. Date of completion July 21, 2023	07/21/2023

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	This finding was acknowledged by the Maintenance Director and Administrator at the time of discovery and again during the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)			