

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2025
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NAME OF PROVIDER OR SUPPLIER PARK PLACE HEALTH AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10820 PARK PLACE SAINT JOHN, IN 46373
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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K 0000 Bldg. 01	<p>A Life Safety Code State Licensure Survey was conducted by the Indiana Department of Health.</p> <p>Survey Date: 05/22/2025</p> <p>Facility Number: 017974 Provider Number: NA AIM Number: NA</p> <p>At this Life Safety Code survey, Park Place Health and Wellness Center was found not in compliance with Requirements of the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility is separated by three distinct buildings identified as Building 1, Building 2, and Building 3. Building 1 (10810 - Faith) is located to the North of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 1 has 10 beds. Building 2 (10820 - Main) is a two-story building and was determined to be of Type II (111) construction and fully sprinklered. Building 2 has 15 beds on the first floor and 15 beds on the second floor. Building 3 (10830 - Hope) is located to the South of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 3 has 10 beds. The facility has smoke detection in corridors and areas open to the corridor. Smoke detectors hard wired to the fire alarm system are installed in all resident rooms. All three buildings have emergency power supplied by a 250-kW diesel-powered generator. The facility has a total capacity of 56 beds and had a census of 40 at the</p>	K 0000	The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Wolf	Executive Director	06/06/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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K 0046 Bldg. 01	<p>time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/28/25</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generator battery backup lights were tested at 30-day intervals for 30 seconds and annually for a 1 1/2-hour duration to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/22/2025 at 12:02 p.m., no documentation of a 30 second test at 30-day interval or an annual 1 1/2-hour test of the battery backup light located at the emergency generator was available for review. Based on interview with</p>	K 0046	<p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: Documentation for testing battery backup emergency generator lighting has been initiated as of 6/2/25. No further corrective actions taken.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents, staff and visitors are potentially affected by the alleged deficient practice. Monthly TELS-generated audit has been initiated to ensure all emergency lighting testing is completed in proper timeframe and that documentation is recorded on tracking log.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p>	06/13/2025

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	<p>the Maintenance Director on 05/22/2025 at 12:02 p.m., he stated "No. No 90-minute test.", when asked about testing of the emergency battery backup lights. He stated all emergency lighting was on the generator, but acknowledged an emergency flashlight was located at the generator. Based on observation with the Maintenance Director on 05/22/2025 at approximately 1:35 p.m., an emergency flashlight was located at the emergency generator. The Maintenance Director demonstrated the flashlight was operational and stated he tested it regularly but acknowledged no documentation of the testing was available.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>The Maintenance Director has been educated on conducting testing for battery backup emergency generator lighting at 30-day intervals for 30 seconds, testing annually for 90 minutes, and that all testing must be recorded on tracking log. Testing of battery backup emergency generator lighting will be conducted at 30-day intervals for 30 seconds and annually for 90 minutes ongoing, with all tests being documented in tracking log. The Maintenance Director or designee will audit emergency lighting testing monthly for 6 months.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>The Maintenance Director or designee will provide a report of monthly emergency lighting testing monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p>	

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K 0076 Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect one resident in room 9.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/22/2025 at 1:45 p.m., there was one "E" oxygen cylinder freestanding in resident room 9 without support. Based on interview with the Maintenance Director on 05/22/2025 at 1:45 p.m., he acknowledged the "E" cylinder was not in a rack or properly secured with the chain.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>	K 0076	<p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:</p> <p>The freestanding "E" oxygen cylinder in resident room 9 without support was removed and secured in proper cylinder storage stand.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:</p> <p>One resident in room 9 was potentially affected by the alleged deficient practice. Audit has been completed to ensure all "E" oxygen cylinders in use are either properly chained or supported in a proper cylinder stand or cart.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>The Maintenance Director, Director of Nursing, and Housekeeping Supervisor have been educated on ensuring all "E" oxygen cylinders in use are either properly chained or supported in a proper cylinder stand or cart. A monthly audit will be conducted for 6 months by the Director of Nursing or designee to ensure all "E" oxygen cylinders in use are either properly chained or supported in a proper cylinder</p>	06/13/2025
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K 0000 Bldg. 02	<p>A Life Safety Code State Licensure Survey was conducted by the Indiana Department of Health.</p> <p>Survey Date: 05/22/2025</p> <p>Facility Number: 017974 Provider Number: NA AIM Number: NA</p> <p>At this Life Safety Code survey, Park Place Health and Wellness Center was found not in compliance with Requirements of the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p>	K 0000	<p>stand or cart.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>Director of Nursing or designee will provide report of properly secured "E" oxygen cylinders in use monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p> <p>The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies</p>	

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K 0020 Bldg. 02	<p>This facility is separated by three distinct buildings identified as Building 1, Building 2, and Building 3. Building 1 (10810 - Faith) is located to the North of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 1 has 10 beds. Building 2 (10820 - Main) is a two-story building and was determined to be of Type II (111) construction and fully sprinklered. Building 2 has 15 beds on the first floor and 15 beds on the second floor. Building 3 (10830 - Hope) is located to the South of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 3 has 10 beds. The facility has smoke detection in corridors and areas open to the corridor. Smoke detectors hard wired to the fire alarm system are installed in all resident rooms. All three buildings have emergency power supplied by a 250-kW diesel-powered generator. The facility has a total capacity of 56 beds and had a census of 40 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/28/25</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on observation and interview, the facility failed to ensure exit stairways on 2 of 2 floors were enclosed with construction providing a fire resistance of at least 1 hour. This deficient practice affects residents, staf and visitors in 1 of 3 buildings</p>	K 0020	<p>Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.</p> <p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: The north and south stairwell doors on first floor of AL building have proper fire resistance rating</p>	06/13/2025

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/22/2025 at 12:16 p.m., the fire rating for the following stairway doors could not be determined:</p> <p>a. North stairway on the first floor, had no rating label, and the door edge was covered by a piano hinge;</p> <p>b. North stairway on the second floor, had no rating label, and the door edge was covered by a piano hinge;</p> <p>c. South stairway on the first floor, had no rating label, and the door edge was covered by a piano hinge;</p> <p>d. South stairway on the second floor, had no rating label, and the door edge was covered by a piano hinge;</p> <p>Based on interview with the Maintenance Director on 05/22/2025 at 12:16 p.m., he acknowledged the doors did not have labels or markings to indicate a fire resistance rating. During the exit conference the Maintenance Director provided documentation of fire ratings for doors; however, it could not be determined if the stairway doors were included in the documentation.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>labels on top edge of the doors, no further action taken. The north and south stairwell doors on the second floor of AL have partially obscured fire resistance rating labels on bottom edge of both doors.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:</p> <p>All residents, staff and visitors in 1 of 3 buildings are potentially affected by the alleged deficient practice. The AL building is the only building out of 3 buildings with stairwells between floors: no further action taken in building 2 of 3 or building 3 of 3 to identify further potential risk to residents, staff, and visitors.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>All north and south stairwell doors on the second floor of the AL building with partially obscured fire resistance rating labels are to be inspected by third-party vendor Intertek on 6/6/25; any doors identified as not having proper fire resistance rating labels will have label applied to door. The Maintenance Director has been educated on ensuring all stairwell doors in AL building have fire</p>		

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K 0046 Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generator battery backup lights were tested at 30-day intervals for 30 seconds and annually for a 1 1/2-hour duration to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with</p>	K 0046	<p>resistance rating labels on them and that documentation must be maintained that shows fire resistance rating of each door.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>The Maintenance Director or designee will ensure that fire rating documentation is updated in facility records to properly identify the fire rating of all affected doors in the north and south stairwells of AL building. Door fire rating documentation for the north and south stairwells of AL building will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p> <p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: Documentation for testing battery backup emergency generator lighting has been initiated as of 6/2/25. No further corrective</p>	06/13/2025

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	<p>Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/22/2025 at 12:02 p.m., no documentation of a 30 second test at 30-day interval or an annual 1 1/2-hour test of the battery backup light located at the emergency generator was available for review. Based on interview with the Maintenance Director on 05/22/2025 at 12:02 p.m., he stated "No. No 90-minute test.", when asked about testing of the emergency battery backup lights. He stated all emergency lighting was on the generator, but acknowledged an emergency flashlight was located at the generator. Based on observation with the Maintenance Director on 05/22/2025 at approximately 1:35 p.m., an emergency flashlight was located at the emergency generator. The Maintenance Director demonstrated the flashlight was operational and stated he tested it regularly but acknowledged no documentation of the testing was available.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>actions taken.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:</p> <p>All residents, staff and visitors are potentially affected by the alleged deficient practice. Monthly TELS-generated audit has been initiated to ensure all emergency lighting testing is completed in proper timeframe and that documentation is recorded on tracking log.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>The Maintenance Director has been educated on conducting testing for battery backup emergency generator lighting at 30-day intervals for 30 seconds, testing annually for 90 minutes, and that all testing must be recorded on tracking log. Testing of battery backup emergency generator lighting will be conducted at 30-day intervals for 30 seconds and annually for 90 minutes ongoing, with all tests being documented in tracking log. The Maintenance Director or designee will audit emergency lighting testing monthly for 6 months.</p>	

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K 0052 Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems to assure that it had accurate time and date information in accordance with the requirements of NFPA 101- 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 7.1, 7-1.1.1. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/22/2025 at 12:31 p.m., the time and date on the fire alarm control panel were incorrect. The display on the fire alarm control panel</p>	K 0052	<p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>The Maintenance Director or designee will provide a report of monthly emergency lighting testing monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p> <p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:</p> <p>The date and time on the fire alarm control panel display has been corrected and now shows the current date and time.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:</p> <p>All residents, staff and visitors in 1 of 3 buildings are potentially</p>	06/13/2025

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	<p>indicated the date and time to be 05/22/25 at 11:31 a.m. Based on interview with the Maintenance Director on 05/22/2025 at 12:31 p.m., he indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>affected by the alleged deficient practice. Audit has been completed for all fire alarm control panel displays to ensure they show the correct date and time; no further corrective actions taken.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>The Maintenance Director has been educated on ensuring all fire alarm control panels display the proper date and time. A monthly audit will be conducted for 6 months by the Maintenance Director or designee to ensure all fire alarm control panels display the proper date and time.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>The Maintenance Director or designee will provide a report of fire alarm control panel displays monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p>	

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K 0062 Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice affects residents, staff and visitors in 1 of 3 buildings.</p> <p>Findings include:</p> <p>a) Based on observation with the Maintenance Director on 05/22/2025 at 12:18 p.m., linens were stacked on a shelf in the linen closet located on the second floor across from resident room 204. The linens were stacked within 12 inches from the bottom of a sprinkler deflector not allowing the minimum 18-inch clearance. Based on interview with the Maintenance Director on 05/22/2025 at 12:18 p.m., he stated he estimated the linens were within 12 inches from the bottom of the sprinkler deflector.</p> <p>b) Based on observation with the Executive Director and Maintenance Director on 05/22/2025 at 1:07 p.m., linens were stacked on a shelf in the linen closet located on the 1st floor across from resident room 104. Based on interview with the Maintenance Director on 05/22/2025 at 1:07 p.m., he stated he estimated the linens were within 8 inches from the bottom of the sprinkler deflector.</p>	K 0062	<p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: All linens in second floor AL linen closet have been restacked to ensure they are a minimum of 18" clearance from the bottom of the sprinkler deflector. Any overstock linen has been stored in AL basement.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents, staff and visitors in 1 of 3 buildings are potentially affected by the alleged deficient practice. Audit has been completed for all linen closets to ensure linens are at minimum 18" away from bottom of sprinkler deflector.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur: The Maintenance Director and Housekeeping Supervisor have been educated on keeping linens at least 18" away from bottom of the sprinkler deflector in linen closets. A monthly audit will be conducted for 6 months by the Maintenance Director,</p>	06/13/2025
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2025
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NAME OF PROVIDER OR SUPPLIER PARK PLACE HEALTH AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10820 PARK PLACE SAINT JOHN, IN 46373
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K 0064 Bldg. 02	<p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers on the first floor near the nurses station was readily accessible. NFPA 10, 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal</p>	K 0064	<p>Housekeeping Supervisor, or designee to ensure all linens are stored at least 18" away from the bottom of the sprinkler deflector in linen closets.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p> <p>Maintenance Director, Housekeeping Supervisor, or designee will provide monthly report of all linen stored in linen closets being at minimum 18" away from sprinkler deflector to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p> <p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: Nurses' mobile computer cart parked in front of the fire extinguisher located across from the nurses station on first floor of</p>	06/13/2025

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	<p>paths of travel, including exits from areas. NFPA 10, 1-6.6 requires fire extinguishers shall not be obstructed or obscured from view. This deficient practice affects all residents in the Main building, first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/22/2025 at 1:11 p.m., access to the fire extinguisher located across from the nurses station on the first floor of the Main building was blocked from view and access by a nurse's cart. Based on interview with the Maintenance Director on 05/22/2025 at 1:11 p.m., he acknowledged the blocked extinguisher at the time of the observation and moved the nurse's cart immediately.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>the main building was moved away from the fire extinguisher wall cabinet while Life Safety surveyor was present.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents, staff and visitors in the main building, first floor are potentially affected by the alleged deficient practice. Audit has been completed to ensure all fire extinguisher wall cabinets are not blocked or obstructed.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur: The Maintenance Director, Director of Nursing, and Housekeeping Supervisor have been educated about not blocking or obstructing fire extinguisher wall cabinets. A monthly audit will be conducted for 6 months by the Maintenance Director, Housekeeping Supervisor, or designee to ensure all fire extinguisher wall cabinets are unobstructed.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved: Maintenance Director or designee</p>	

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K 0000 Bldg. 03	<p>A Life Safety Code State Licensure Survey was conducted by the Indiana Department of Health.</p> <p>Survey Date: 05/22/2025</p> <p>Facility Number: 017974 Provider Number: NA AIM Number: NA</p> <p>At this Life Safety Code survey, Park Place Health and Wellness Center was found not in compliance with Requirements of the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility is separated by three distinct buildings identified as Building 1, Building 2, and Building 3. Building 1 (10810 - Faith) is located to the North of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 1 has</p>	K 0000	<p>will provide report of unobstructed fire extinguisher wall cabinets monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.</p> <p>The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these</p>	

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K 0046 Bldg. 03	<p>10 beds. Building 2 (10820 - Main) is a two-story building and was determined to be of Type II (111) construction and fully sprinklered. Building 2 has 15 beds on the first floor and 15 beds on the second floor. Building 3 (10830 - Hope) is located to the South of the main building. It is a one-story building and was determined to be of Type V (111) construction and fully sprinklered. Building 3 has 10 beds. The facility has smoke detection in corridors and areas open to the corridor. Smoke detectors hard wired to the fire alarm system are installed in all resident rooms. All three buildings have emergency power supplied by a 250-kW diesel-powered generator. The facility has a total capacity of 56 beds and had a census of 40 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/28/25</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generator battery backup lights were tested at 30-day intervals for 30 seconds and annually for a 1 1/2-hour duration to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2</p>	K 0046	<p>findings.</p> <p>1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: Documentation for testing battery backup emergency generator lighting has been initiated as of 6/2/25. No further corrective actions taken.</p> <p>2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:</p>	06/13/2025

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	<p>hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/22/2025 at 12:02 p.m., no documentation of a 30 second test at 30-day interval or an annual 1 1/2-hour test of the battery backup light located at the emergency generator was available for review. Based on interview with the Maintenance Director on 05/22/2025 at 12:02 p.m., he stated "No. No 90-minute test.", when asked about testing of the emergency battery backup lights. He stated all emergency lighting was on the generator, but acknowledged an emergency flashlight was located at the generator. Based on observation with the Maintenance Director on 05/22/2025 at approximately 1:35 p.m., an emergency flashlight was located at the emergency generator. The Maintenance Director demonstrated the flashlight was operational and stated he tested it regularly but acknowledged no documentation of the testing was available.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>		<p>All residents, staff and visitors are potentially affected by the alleged deficient practice. Monthly TELS-generated audit has been initiated to ensure all emergency lighting testing is completed in proper timeframe and that documentation is recorded on tracking log.</p> <p>3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>The Maintenance Director has been educated on conducting testing for battery backup emergency generator lighting at 30-day intervals for 30 seconds, testing annually for 90 minutes, and that all testing must be recorded on tracking log. Testing of battery backup emergency generator lighting will be conducted at 30-day intervals for 30 seconds and annually for 90 minutes ongoing, with all tests being documented in tracking log. The Maintenance Director or designee will audit emergency lighting testing monthly for 6 months.</p> <p>4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:</p>	

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

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			The Maintenance Director or designee will provide a report of monthly emergency lighting testing monthly to Quality Assurance Committee for 6 months. Reports will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.		