CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039	
AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150045	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 05/12/2021
NAME OF PROVIDER OR SUPPLIER  PARKVIEW DEKALB HOSPITAL			1316 E	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST	
			AUBUF	RN, IN 46706	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
A 0000					
Bldg. 00	This visit was for a re-certification and survey.	Federal hospital a Focused Infection Control	A 0000		
	Parkview Dekalb H	205041 20-12/2021 and 05/24-25/2021 30-12/2021 and 05/24-25/2021 30-12/202			
A 0700 Bldg. 00	and maintained to patient, and to pro and treatment and services appropria community.  Based on record reinterview, the facilitation to ensure complete was provided for 2 accordance with NI failed to maintain 1		A 0700	1. How are you, the provider, going to correct the finding and/or deficiency? If already corrected, include the following steps and state date of correction.  a. The door latch for Room 9 in the emergency departme was replaced by facilities on June 2, 2021. Door latches 1, 5 and 6 in ICU were fixed on	e e n nt

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

rooms (see tag K353).

TITLE

How are you, the

2.

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3Z5N11 Facility ID: 005041 If continuation sheet Page 1 of 11

i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150045	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  05/12/2021
	PROVIDER OR SUPPLII		1316 E	ADDRESS, CITY, STATE, ZIP COD E SEVENTH ST RN, IN 46706	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	The cumulative ef resulted in the hos locations from wh constructed, arran	fect of these systemic problems pital's inability to ensure that all ich it provides services are ged and maintained to ensure nality health care in a safe		provider, going to prevent the finding and/or deficiency from recurring in the future, even already corrected?  a. To prevent this from happening in the future, we will ensure that door latches are checked during Environment of Care rounds biannually within the departments.  b. Memo to mangers of each department reminding staff to create work orders when issues within their department are identified.  3. Who is going to be responsible for numbers 1 at 2 above, i.e. administrator, director of nursing, head housekeeper, dietary supervisor, maintenance supervisor, etc.?  a. Environment of Care Team will be responsible for identifying issues with door latches during rounding in department biannually.  b. Facilities Manager or designee(s) will be responsifor fixing future identified issues with latches.  c. Unit manager or design will be responsible for as needed work orders being placed when issues with latches identified.  4. By what date are you the provider going to hat the finding and/or deficiency	ne om if  be nee

If continuation sheet

07/28/2021 PRINTED:

A. BUILDING 00 COM 150045  STREET ADDRESS, CITY, STATE, ZIP COD 1316 E SEVENTH ST AUBURN, IN 46706  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Deficiency  Corrected?  a. The room 9 ER door was fixed as of 6/2/2021 and the CCU door latches were fixed		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW DEKALB HOSPITAL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Deficiency  Corrected?  a. The room 9 ER door was fixed as of 6/2/2021 and the CCU door latches were fixed	(X3) DATE SURVEY COMPLETED 05/12/2021	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Corrected?  a. The room 9 ER door was fixed as of 6/2/2021 and the CCU door latches were fixed		
on 6/3/2021.  1. How are you, the provider, going to correct the finding and/or deficiency? If already corrected, include the following steps and state date of correction.  a. New sprinklers will be installed in the walk-in-freezer and walk-in-cooler by a Fire Systems Company contracted by the hospital.  2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected.  a. Once installed, the sprinkler systems in these areas will be compliant and this will not recur.  3. Who is going to be responsible for numbers 1 & 2 above?  a. Facilities manager  4. By what date are you, the provider, going to have the	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3Z5N11

Facility ID: 005041

installation in both the walk-in-freezer and walk-in-refrigerator in the dietary department.

If continuation sheet

Page 3 of 11

PRINTED: 07/28/2021 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150045  NAME OF PROVIDER OR SUPPLIER  PARKVIEW DEKALB HOSPITAL		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/12/2021	
		STREET 1316 E AUBUF			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				b. Working with contractor to schedule installation with completion date by August 24th, 2021.  1. How are you, the provider, going to correct the finding and/or deficiency? If already corrected, include the following steps and state date of correction.  a. The internal sprinkler system pipe inspection will be conducted by the Fire System Company contracted by the hospital.  2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected?  a. This service will be performed every 5 years in accordance with 19.3.5.3. NFF 25, 2011 Edition, 14.2.1, by a Fire Systems Company contracted by the hospital.  3. Who is going to be responsible for numbers 1 & 3.  a. Facilities manager will be responsible for scheduling contracted service with the Fi Systems Company every 5 years.  4. By what date are you the provider going to have the finding and/or deficiency corrected?	e e e e e e e e e e e e e e e e e e e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3Z5N11

Facility ID: 005041

If continuation sheet

A quote was obtained

Company on May 26, 2021 for

from the Fire Systems

Page 4 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150045		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2021	
	ROVIDER OR SUPPLIER		1316 E	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST	
PARKVIE	W DEKALB HOSP	ITAL	AUBUF	RN, IN 46706	
	SUM DEKALB HOSP SUMMARY (EACH DEFICIEN		1316 E		be by e min if as if as in the company of the compa
				finding and/or deficiency corrected?  a. This was corrected on 5/27/2021.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3Z5N11

Facility ID: 005041

If continuation sheet

Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
150045		B. WIN	NG		05/12/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW DEKALB HOSPITAL			1316 E	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST RN, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG A 0701 Bldg. 00	482.41(a) MAINTENANCE Of The condition of the overall hospital endeveloped and mathat the safety and assured.  1. Based on record facility failed to mathat accordance with 19.14.2.1 states except 14.2.1.4 an inspectic conditions shall be opening a flushing of main and by removing of one branch line from the presence of it material. This defic occupants.  Findings include:  Based on records responsible of facilities, the Facilities, the Facilities, the Facilities, and documentation to internal pipe inspection paper work inspection paper work inspection paper work.	DF PHYSICAL PLANT ne physical plant and the vironment must be aintained in such a manner d well-being of patients are  review and interview, the intain 1 of 1 sprinkler system in 3.5.3. NFPA 25, 2011 Edition, as discussed in 14.2.1.1 and on of piping and branch line conducted every 5 years by connection at the end of one ing a sprinkler toward the end for the purpose of inspecting foreign organic and inorganic ient practice could affect all  view with the Vice President cilities Manager, and the Safety 24/21 at 10:34 a.m., there was a show when the last time an tion was conducted on the when the next inspection was view at the time of record is Manager did not know if or al pipe inspection was d not find internal pipe	A 07		1. How are you, the provider, going to correct the finding and/or deficiency? If already corrected, include th following steps and state dat of correction.  a. The internal sprinkler system pipe inspection will be conducted by the Fire System Company contracted by the hospital.  2. How are you, the provider, going to prevent the finding and/or deficiency from the recurring in the future, even already corrected?  a. This service will be performed every 5 years in accordance with 19.3.5.3. NF 25, 2011 Edition, 14.2.1, by a Fire Systems Company contracted by the hospital.  3. Who is going to be responsible for numbers 1 & a. Facilities manager will be responsible for scheduling contracted service with the F Systems Company every 5 years.	O8/24/2021 e f ne te  be m if
	of 1 of 1 I.T. rooms and gases around th	intain the ceiling construction  The ceiling tiles trap hot air e sprinkler and cause the at a specified temperature.			4. By what date are you th provider going to have the finding and/or deficiency corrected?	ne

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		150045	B. W	ING		05/12/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			SEVENTH ST		
PARKVIE	EW DEKALB HOSF	PITAL	_		RN, IN 46706		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ition, 8.5.4.11 states the distance			a. A quote was obtained		
	-	ler deflector and the ceiling			from the Fire Systems		
		cted based on the type of			Company on May 26, 2021 fo	r	
	-	rpe of construction. This			the internal sprinkler pipe		
	_	ould affect 5 patients in suite			inspection.		
	five.				b. The internal sprinkler		
	F' 1' ' 1 1				system pipe inspection will I		
	Findings include:				scheduled with completion b	y	
	D 1 1	1			August 24, 2021.		
		on during a tour of the facility			1. How are you, the	_	
		dent of Facilities, the Facilities			provider, going to correct th		
	Manager, and the Safety Coordinator on 05/25/21 at 1:30 p.m., the suspended ceiling in the suite five I.T. room had two ceiling tiles missing. This				finding and/or deficiency fro		
					recurring in the future, even	IT	
		ay the activation of the			already corrected?		
		on the suspended ceiling.			a. Ceiling tiles identified a	15	
	Based on interview	-			missing in Suite 5, IT room were replaced on 5/27/2021		
		acilities Manager stated the			2. How are you, the		
		not replace the tiles after			provider, going to prevent th	10	
	completing work.	not replace the thes arei			finding and/or deficiency fro		
	completing work.				recurring in the future, even		
	The findings were	reviewed with the Vice			already corrected.	"	
	_	ies, the Facilities Manager, and			a. Contractors will be		
		ator during the exit conference.			educated about the importar	ıce	
					of making sure all ceiling tile		
					are replaced when they are	,,,	
					finished with a job.		
					b. Ceiling tiles will be		
					observed during Environmen	nt	
					of Care (EOC) rounds		
					Biannually and as needed.		
					3. Who is going to be		
					responsible for numbers 1 &	<b>.</b> 2	
					above?		
					a. Facilities Manager		
					b. EOC rounding team		
					4. By what date are you, t	he	
					provider going to have the		
					finding and/or deficiency		
					corrected?		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
150045				05/12/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW DEKALB HOSPITAL		1316 E	SEVENTH ST		
		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)	DATE	
			a. This was corrected on 5/27/2021.		
OM FIRE					
	A 0'	709	How are you, the	08/24/2021	
plete automatic sprinkler I for 2 of 2 walk-in ordance with NFPA 13-2010, allation of Sprinkler Systems, coverage for all portions of eficient practice could affect the in the kitchen and dining  In during a tour of the facility ent of Facilities, the Facilities fety Coordinator on 05/25/21 alk-in cooler and walk-in freezer not provided with sprinkler interview during observation, er agreed the walk-in cooler is provided with sprinklers.  In the walk-in cooler is provided with sprinklers.			finding and/or deficiency? If already corrected, include th following steps and state dat of correction.  a. New sprinklers will be installed in the walk-in-freeze and walk-in-cooler by a Fire Systems Company contracted by the hospital.  2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even already corrected.  a. Once installed, the sprinkler systems in these areas will be compliant and this will not recur.  3. Who is going to be responsible for numbers 1 & above?  a. Facilities manager  4. By what date are you, the provider, going to have the finding and/or deficiency corrected?  a. Received quote from the Fire Systems company on July 4, 2021 for the sprinkler installation in both the	e e de	
	150045	TAL  TATEMENT OF DEFICIENCIE  EY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  DM FIRE  Te  In and interview, the facility plete automatic sprinkler If for 2 of 2 walk-in ordance with NFPA 13-2010, allation of Sprinkler Systems, coverage for all portions of efficient practice could affect the in the kitchen and dining  In during a tour of the facility ent of Facilities, the Facilities fety Coordinator on 05/25/21 alk-in cooler and walk-in freezer not provided with sprinkler interview during observation, er agreed the walk-in cooler is provided with sprinklers.  It was a series of the president ilities Manager, and the Safety	TAL  TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  DM FIRE THE THE THE THE THE THE THE THE THE TH	TAL  TATEMENT OF DEFICIENCIE  LY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  TAG  A 0709  1. How are you, the provider, going to corrected on 5/27/2021.  A 0709  1. How are you, the provider, going to correct the finding and/or deficiency? If already corrected, include the following steps and state dat of correction.  a. New sprinklers will be installed in the walk-in-freezer and walk-in-cooler by a Fire Systems Company contracte by the hospital.  2. How are you, the provider, going to correct the following steps and state dat of correction.  a. New sprinklers will be installed in the walk-in-freezer and walk-in-cooler by a Fire Systems Company contracte by the hospital.  2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even already corrected.  a. Once installed, the sprinkler systems in these areas will be compliant and this will not recur.  3. Who is going to be responsible for numbers 1 & above?  a. Facilities manager  4. By what date are you, the provider, going to have the finding and/or deficiency corrected?  a. Received quote from the Fire Systems company on Jut, 2021 for the sprinkler	STREET ADDRESS, CITY, STATE, ZIP COD   1316 E SEVENTH ST AUBURN, IN 46706

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3Z5N11

Facility ID: 005041

If continuation sheet

Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150045		(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 05/12/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW DEKALB HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP COD 1316 E SEVENTH ST AUBURN, IN 46706			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				dietary department. b. Working with contract to schedule installation with completion date by August 24th, 2021.	
A 0720	482.41(c)				
Bldg. 00	otherwise provide hospital must mee and must proceed Health Care Facili Tentative Interim (12-3, TIA 12-4, TI. (1) Chapters 7, 8, Health Care Facili hospital.  (2) If application of Code required und section would resign the hospital, C provisions of the hospital must be considered to the hospital, C provisions of the hospital must be considered to the hospital, C provisions of the hospital must be considered to the hospital of the hospital o	ding safety. Except as d in this section, the et the applicable provisions in accordance with the ties Code (NFPA 99 and Amendments TIA 12-2, TIA A 12-5 and TIA 12-6).  12, and 13 of the adopted ties Code do not apply to a fine Health Care Facilities der paragraph (c) of this cult in unreasonable hardship MS may waive specific Health Care Facilities Code, wer does not adversely			
	Based on observation failed to ensure 5 or doors in ICU and the provided with mean LSC 19.3.6.3.5 state a means for keeping acceptable to the aud LSC 19.2.2.10.1 states permitted by 7.2. automatic-closing stands shall have a latest states of the states o	on and interview, the facility of 15 horizontal-sliding room the Emergency Department were the for keeping the door closed. The door closed that is thority having jurisdiction. The states horizontal-sliding doors, of the belimited to a single leaf the or other mechanism that the states will not rebound into a	A 0720	1. How are you, the provider, going to correct the finding and/or deficiency? It already corrected, include the following steps and state date of correction.  a. The door latch for Roomal 9 in the emergency department was replaced by facilities or June 2, 2021. Door latches 5 and 6 in ICU were fixed on June 3, 2021.  2. How are you, the	ne f he ate om eent 1, 2,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 005041

3Z5N11

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUI A. BUI		ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
150045		B. WIN	G		05/12/2021	
	PROVIDER OR SUPPLIE			1316 E	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST N, IN 46706	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	partially open pos	ition if forcefully closed. This			provider, going to prevent th	ne e
	deficient practice	could affect 5 patients.			finding and/or deficiency fro	m
	Findings include:				recurring in the future, even already corrected?	if
	D 1 1	. 1			a. To prevent this from	
		ion during a tour of the facility			happening in the future, we	
		sident of Facilities, the Facilities			will ensure that door latches	i
	_	Safety Coordinator on 05/25/21 a. and 2:00 p.m., patient rooms 1,			are checked during Environment of Care rounds	
		and room 9 in the Emergency			biannually within the	ı
		provided with horizontal-sliding			departments.	
		were provided with latches, but			b. Memo to mangers of	
		pors did not latch into the frame.			each department reminding	
	Based on interview	w during observation, the			staff to create work orders	
		r agreed the doors did not latch			when issues within their	
	into the door fram	e when tested and stated the			department are identified.	
	door latches will r	need to be repaired.			3. Who is going to k	ре
					responsible for numbers 1 a	nd
		eviewed with the Vice President			2 above, i.e. administrator,	
		acilities Manager, and the Safety			director of nursing, head	
	Coordinator durin	g the exit conference.			housekeeper, dietary	
					supervisor, maintenance	
					supervisor, etc.?	
					a. Environment of Care	
					Team will be responsible for	
					identifying issues with door	
					latches during rounding in department biannually.	
					b. Facilities Manager or	
					designee(s) will be responsi	ble
					for fixing future identified	~.0
					issues with latches.	
					c. Unit manager or design	nee
					will be responsible for as	
					needed work orders being	
					placed when issues with	
					latches identified.	
					4. By what date are	
					you the provider going to ha	ive
					the finding and/or deficiency	<i>,</i>

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

PRINTED: 07/28/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150045	ì í	JILDING	onstruction 00	(X3) DATE : COMPL 05/12/	ETED
NAME OF PROVIDER OR SUPPLIER PARKVIEW DEKALB HOSPITAL				1316 E	ADDRESS, CITY, STATE, ZIP COD SEVENTH ST N, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
S 0000 Bldg. 00	The visit was for a Survey.  Facility Number: 0  Survey Date: 5/10-  Parkview Dekalb H	State Hospital licensure	S 00		corrected? a. The room 9 ER door w fixed as of 6/2/2021 and the CCU door latches were fixed on 6/3/2021.	as	

State Form Event ID: 3Z5N11 Facility ID: 005041 If continuation sheet Page 11 of 11