STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING -- B. WING	05/25/2021

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PARKVIEW DEKALB HOSPITAL	1316 E SEVENTH ST AUBURN, IN 46706

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.15 Survey Date: 05/24/21 through 05/25/21 Facility Number: 005041 Provider Number: 150045 AIM Number: 100269460A At this Emergency Preparedness survey, Parkview Dekalb Hospital was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 482.15 The facility has a capacity of 56 with a census of 18 on 05/24/21 and a census of 22 on 05/25/21. Quality Review completed on 05/27/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 05/24/21 through 05/25/21 Facility Number: 005041 Provider Number: 150045 AIM Number: 100269460A At this Life Safety Code survey, Parkview Dekalb Hospital was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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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	Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19 Existing Health Care occupancies. The facility is a three-story building. The original 1964 building and the 1976, 1992, 2001, 2014 additions was determined to be Type I (332) construction and the 2008 and 2011 Emergency Department addition was determined to be Type I (222). The facility is fully sprinklered, with exception of the walk-in cooler and freezer, and has a monitored fire alarm system with smoke detection in the corridors and spaces open to the corridors and in the operating rooms. The facility is protected with a Type 1 EES by three generators. The facility has a capacity of 56 with a census of 18 on 05/24/21 and a census of 22 on 05/25/21. Quality Review completed on 05/27/21			
K 0224 Bldg. 01	NFPA 101 Horizontal Sliding Doors Horizontal-Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: o Area served by the door has no high hazard contents. o Door is operable from either side without special knowledge or effort. o Force required to operate the door in the direction of travel is less than or equal to 30			

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	lbf to set the door in motion and less than or equal to 15 lbf to close or open to the required width. o Assembly is appropriately fire rated, and where rated, is self-closing or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. o Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 19.2.2.2.10 Based on observation and interview, the facility failed to ensure 5 of 15 horizontal-sliding room doors in ICU and the Emergency Department were provided with means for keeping the door closed. LSC 19.3.6.3.5 stated doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction. LSC 19.2.2.2.10.1 states horizontal-sliding doors, as permitted by 7.2.1.14, that are not automatic-closing shall be limited to a single leaf and shall have a latch or other mechanism that ensures that the doors will not rebound into a partially open position if forcefully closed. This deficient practice could affect 5 patients. Findings include: Based on observation during a tour of the facility with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/25/21 between 11:20 a.m. and 2:00 p.m., patient rooms 1, 2, 5, and 6 in ICU and room 9 in the Emergency Department were provided with horizontal-sliding doors. The doors were provided with latches, but when tested the doors did not latch into the frame. Based on interview during observation, the Facilities Manager agreed the doors did not latch into the door frame when tested and stated the door latches will need to be repaired.	K 0224	**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 department was replaced by facilities on June 2, 2021. Door latches 1, 2, 5 and 6 in ICU were fixed on June 3, 2021.** **2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if 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.**	06/03/2021

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	The finding was reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.		**3. Who is going to be responsible for numbers 1 and 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 responsible for fixing future identified issues with latches.** **c. Unit manager or designee 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 have the finding and/or deficiency 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.**	
K 0232 Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.			

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	19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 8 fist floor corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 patients in the OB/Rehab outpatient hall. Findings include: Based on observation during a tour of the facility	K 0232	**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 furniture was removed for the OB Outpatient /Cardiac Rehab exit hallway on 5/27/2021.** **2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected?** **a. Furniture will not be reinstalled in this hallway unless it meets the guidelines as stated in LSC 19.2.3.4(5).** **3. Who is going to be responsible for numbers 1 and 2 above?** **a. Facilities manager will be responsible for ensuring that if furniture is installed it will meet the LSC 19.2.3.4(5) guidelines.** **4. By what date are you, the provider, going to have the finding or deficiency corrected?** **a. This deficiency was corrected on 05/27/2021.**	05/27/2021

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	with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/25/21 at 1:20 p.m., chairs and a bench were in the OB/Rehab outpatient exit corridor, extended about two feet into the corridor, and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Facilities Manager agreed the chairs and bench were not securely attached to the floor or to the wall when tested. The finding was reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.			
K 0321 Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms			

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	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 walk-in clinic janitor closets containing trash and soiled linens was protected as a hazardous area. This deficient practice could affect 10 patients in the walk-in clinic. Findings include: Based on observation during a tour of the facility with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/25/21 at 2:10 p.m., the walk-in clinic janitor closet contained bags of trash and soiled linens. The closet was not protected as a hazardous area because the corridor door to the closet was not self-closing or automatic closing. Based on interview at the time of observation, the Facilities Manager agreed the janitor closet contained soiled linens and trash, and the corridor door to the room was not self-closing. The finding was reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.	K 0321	**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. **Facilities installed an automatic closure on the door in question on 6/2/2021** **2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected.** a. **Now that the automatic closure is in place this will not recur.** **3. Who is going to be responsible for 1 & 2 above?** a. **Facilities manager** **4. By what date are you, the provider, going to have the finding and/or deficiency corrected?** a. **The automatic closure was installed on the door in the Walk-in-Clinic on 6/2/2021.**	06/02/2021

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K 0351 Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 2 of 2 walk-in cooler/freezer in accordance with NFPA 13-2010, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect up to 30 people in the in the kitchen and dining area. Findings include: Based on observation during a tour of the facility with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/25/21 at 12:30 p.m., the walk-in cooler and walk-in freezer	K 0351	**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.**	08/24/2021

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	in the kitchen were not provided with sprinkler coverage. Based on interview during observation, the Facilities Manager agreed the walk-in cooler and freezer were not provided with sprinklers. The finding was reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.		**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 finding and/or deficiency corrected?** **a. Received quote from the Fire Systems company on June 4, 2021 for the sprinkler installation in both the walk-in-freezer and walk-in-refrigerator in the dietary department.** **b. Working with contractor to schedule installation with completion date by August 24th, 2021.**	
K 0353 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			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on records review with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/24/21 at 10:34 a.m., there was no documentation to show when the last time an internal pipe inspection was conducted on the sprinkler system, or when the next inspection was due. Based on interview at the time of record review, the Facilities Manager did not know if or when the last internal pipe inspection was conducted and could not find internal pipe inspection paperwork. 2. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 I.T. rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the	K 0353	**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 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. This service will be performed every 5 years in accordance with 19.3.5.3. NFPA 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 & 2?** **a. Facilities manager will be responsible for scheduling contracted service with the Fire Systems Company every 5 years.** **4. By what date are you the provider going to have the finding and/or deficiency corrected?** **a. A quote was obtained from the Fire Systems**	08/24/2021

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	type of construction. This deficient practice could affect 5 patients in suite five. Findings include: Based on observation during a tour of the facility with the Vice President of Facilities, the Facilities 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 condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Facilities Manager stated the I.T. department did not replace the tiles after completing work. The findings were reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.		**Company on May 26, 2021 for the internal sprinkler pipe inspection.** **b. The internal sprinkler system pipe inspection will be scheduled with completion by August 24, 2021.**	
K 0920 Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet			

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	other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 4 of 4 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect staff and patients throughout the building Findings include: Based on observation during a tour of the facility with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator on 05/25/21 between 11:05 a.m. and 2:00 p.m., refrigerators, microwaves, and coffeepots which are high power draw equipment were plugged into and supplied power by a power strips in several staff offices including the case management office and in the OB brake room. Based on interview at the time of observation, the Facilities Manager acknowledged power strips were supplying power to high power draw equipment in staff areas. The finding was reviewed with the Vice President of Facilities, the Facilities Manager, and the Safety Coordinator during the exit conference.	K 0920	**1. How are you, the provider, going to correct the finding and/or deficiency from recurring in the future, even if already corrected?** **a. Ceiling tiles identified as missing in Suite 5, IT room were replaced on 5/27/2021** **2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected.** **a. Contractors will be educated about the importance of making sure all ceiling tiles are replaced when they are finished with a job.** **b. Ceiling tiles will be observed during Environment of Care (EOC) rounds Biannually and as needed.** **3. Who is going to be responsible for numbers 1 & 2 above?** **a. Facilities Manager** **b. EOC rounding team** **4. By what date are you, the provider going to have the finding and/or deficiency corrected?**	05/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING 01 B. WING	05/25/2021

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			a. This was corrected on 5/27/2021. **Response** **1. How are you, the provider going to correct the finding and/or deficiency? If already corrected, include the following steps and date of correction.** a. **All power strips identified during the LS survey were immediately removed from use on 5/25/2021.** **2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future, even if already corrected?** a. **Education to staff about what devices can be plugged into power strips and what needs to be plug directly into outlet.** b. **Will observe for improper use of power strips when conducting Environment of Care rounds in all areas.** **3. Who is going to be responsible for numbers 1 & 2 above?** a. **Safety Officer will send out education to all staff about proper use of power strips.** b. **EOC team will be responsible for conducting observations during rounds.** **4. By what date are you, the provider, going to have the finding and/or deficiency corrected?**	

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			a. **Power strips were removed on 5/25/2021.** b. **Education of staff will be completed by 6/24/2021.**	