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 _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	1316 E SEVENTH ST AUBURN, IN 46706

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.15 Survey Date: 11/16/23 through 11/17/23 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 57 with a census of 19 on 11/16/23 and a census of 16 on 11/17/23. Quality Review completed on 11/27/23	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 11/16/23 through 11/17/23 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 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, and 2014 additions were determined to be Type I (332) construction and the 2008 and 2011 Emergency Department addition were determined to be Type II (222). The facility is fully sprinklered, 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 does have a Category 1 Gas and Vacuum Piped Systems. The facility has a capacity of 57 with a census of 19 on 11/16/23 and a census of 16 on 11/17/23. Quality Review completed on 11/27/23	K 000		
K 131	Multiple Occupancies CFR(s): NFPA 101	K 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 131	Continued From page 1 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the penetration in 4 of 4 fire barrier walls that separated health care from business occupancies was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or	K 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 131	Continued From page 2 floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all staff, visitors, and patients. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/17/23 between 11:00 a.m. and 1:00 p.m., the following separation fire walls had unsealed penetrations. A.) Above the drop ceiling of the second-floor separation fire barrier by lab room A224 had an unsealed one-inch hole through the wall. B.) Above the drop ceiling of the second-floor separation fire barrier in the lab had an unsealed 1/4-inch gap between two pieces of drywall. C.) Above the drop ceiling of the second-floor separation fire barrier to Imaging had two 3-inch pipe sleeve ends that were not sealed. D.) Above the drop ceiling of the second-floor separation fire barrier in the Imaging work room there was a drywall patch covering a hole, but the patch was not sealed leaving a 1/8th of an inch gap between the wall and patch. E.) Above the drop ceiling of the second-floor separation fire barrier by room A239 there were three unsealed 1-inch holes. F.) Above the drop ceiling of the second-floor separation fire barrier by room A202 there was an unsealed 2-inch hole. G.) Above the drop ceiling of the second-floor separation fire barrier by MRI control room had a	K 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 131	Continued From page 3 ½-inch gap around duct work. H.) Above the drop ceiling of the ER area separation fire barrier by the ER lounge had an unsealed 2-inch hole. I.) Above the drop ceiling by the rolling fire door of the ER area separation fire barrier had an unsealed 2-inch hole. J.) Above the drop ceiling of the ER area separation fire barrier by triage had a 6-inch pipe sleeve end that was not sealed. K.) Above the drop ceiling of the ER area separation fire barrier by public safety had a 3-inch pipe sleeve that was not sealed around the sleeve and at the end of the sleeve. L.) Above the drop ceiling of the north medical office separation fire barrier had a 3-inch pipe sleeve end that was not sealed. M.) Above the drop ceiling of the MOB separation fire barrier had a 6-inch by 4-inch hole/cutout in the wall. Based on interview at the time of observation, the Facilities Supervisor, the Facilities Manager, and Director of Facilities agreed all four separation fire barriers had unsealed penetrations. The findings were reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 131		
K 161	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 161	Continued From page 4 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building type of II (222) construction by ensuring through penetrations in 1 of 2 two-hour fire floor/ceiling barrier assemblies were maintained to ensure the fire	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 161	Continued From page 5 resistance of the two-hour barrier. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice affects all staff, visitors, and patients. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/17/23 at 12: 30 p.m., on the first floor above the drop ceiling by the triage firewall there was an unsealed 2-inch penetration around a drainage pipe in the two-hour floor/ceiling fire barrier. Based on interview at the time of observation, the Facilities Manager agreed the floor/ceiling fire barrier was not maintained as a two-hour barrier due to the unsealed hole through the barrier. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 161		
K 224	Horizontal Sliding Doors CFR(s): NFPA 101 Horizontal-Sliding Doors	K 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 224	Continued From page 6 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 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 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 2 patients.	K 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 224	Continued From page 7 Findings include: Based on observation during a tour of the facility with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 between 10:00 a.m. and 3:00 p.m., room #1 in ICU and room #9 in the Emergency Department contained horizontal-sliding doors. The doors did contain a latch, 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 frames when tested and stated the door latches will need to be repaired. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of facilities and the Safety Coordinator during the exit conference.	K 224		
K 232	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 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. 19.2.3.4, 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 1 CCU 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	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 232	Continued From page 8 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 10 patients on the CCU wing. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 between 11:50 a.m., there were two chairs and an end table in the CCU hall, extended about two feet	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 232	Continued From page 9 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 table were not securely attached to the floor or to the wall when tested. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 232		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 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 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 321	Continued From page 10 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 imaging storage rooms and 2 of 4 surgery center storerooms was protected as a hazardous area, had latching doors, and contained smoke resisting partitions and doors. This deficient practice could affect staff, visitors, and 7 patients in the Imaging and Surgery Centers. Findings include: A.) Based on observations with Facilities Supervisor and the Safety Coordinator on 11/16/23 at 2:00 p.m., the imaging storeroom contained large amounts of combustible supply boxes, was greater than 50 square feet, and was not protected as a hazardous room. The room was equipped with double set of doors. There was about a ½ inch gap between the doors when the doors were in the closed position. This condition would allow smoke to escape the room in event of a fire. Also, the right door leaf of the set of doors did not have a positive latching device, and the left door leaf latched into the right door leaf which did not latch into the frame. Based on interview at the time of observation, the Facilities Supervisor agreed the room was used as storage, was larger than 50 square feet, stated there was a large gap between the doors when closed, and the doors did not latch into the frame. B.) Based on observations with the Director of Facilities, Facilities Manager, Nursing Quality	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 321	Continued From page 11 Specialist, and the Safety Coordinator on 11/17/23 between 10:00 a.m. and 11:30 a.m., the OR and EVS storerooms contained over 20 boxes of supplies, were greater than 50 square, therefore making the rooms hazardous areas. The storerooms were not protected as a hazardous area because the corridor doors to the rooms were not self-closing or automatic closing. Based on interview at the time of observation, the Facilities Manager agreed the storerooms contained large amount of combustible storage, was larger than 50 square feet, and the corridor doors to the rooms were not self-closing. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 321		
K 331	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This STANDARD is not met as evidenced by: Based on observation, records review, and interview, the facility failed to ensure 2 of 2 rooms with unfinished interior walls used materials in accordance with LSC 19.3.3.1. and 10.2.3.4.	K 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 331	Continued From page 12 This deficient practice could affect 10 patients in the Surgery Center. Findings include: Based on observations with the Director of Facilities, Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/17/23 between 10:00 a.m. and 11:30 a.m., in the EVS storeroom and storeroom OR 4 had unfinished walls with exposed insulation and metal studs and 2 walls in OR 4 were completely covered with plastic. Based on records review at 1:25 p.m., there was no documentation of the flame spread rating for the exposed insulation. Based on interview at the time of observation, the Facilities Manager agreed both rooms had unfinished walls with exposed insulation and metal studs with plastic covering 2 of the walls and there was not a plan to finish the walls. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 331		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 353	Continued From page 13 _____ 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 communication rooms accordance LSC and NFPA 13, 2010 edition, at 8.5.4.11., and failed to ensure 1 of 1 sprinkler heads in the morgue were not loaded and covered with foreign material in accordance with LSC and NFPA 25, 2011 edition, at 5.2.1.1.1. This deficient practice affects staff, visitors, and 10 patients in two smoke compartments. Findings include: A.) NFPA 13, 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 type of construction. Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 at 1:23 p.m., in the suspended ceiling IT room 229 there was a ceiling tile missing and exposed the ceiling about one to two feet above the suspended ceiling. 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 Supervisor agreed there was a missing ceiling tile and exposed the ceiling above the drop ceiling.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 353	Continued From page 14 B.) NFPA 25, 5.2.1.1.1 states sprinklers shall not show signs of leakage and are free of corrosion, foreign materials, paint, and physical damage. Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 at 11:30 a.m., the one sprinkler head in the morgue was heavily loaded with foreign materials. Based on interview at the time of observation, the Facilities Manager, confirmed the sprinkler head in the morgue was loaded with foreign materials. The findings were reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 353		
K 361	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 alcoves with a large quantity of combustible storage open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states Spaces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto	K 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 361	Continued From page 15 in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 10 Patients in CCU. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 at 11:45 a.m., the alcove by the supply room in CCU wing was open to the corridor and was being used to store combustible material such as seven plastic totes of gowns. This condition does not protect the corridor from a hazardous storage area. Based on interview at the time of observation, the Facilities Manager agreed the alcove was open to the corridor, contained combustible storage, and stated the seven totes will be removed form the corridor. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 361		
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 372	Continued From page 16 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 13 of 17 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice affects staff, visitors, and all patients. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/17/23 between 11:00 a.m. and 1:00 p.m., above the drop ceiling of the following smoke walls had unsealed penetrations and/or was sealed with material not	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 372	Continued From page 17 meeting ASTM E 814: A.) The smoke wall by the OR nurses' station had a 1-inch unsealed gap between a vent and the drywall and had four unsealed holes in the wall. B.) The smoke wall by PACU had penetrations filled with Joint Compound. C.) The smoke wall by the OR consultation room had a penetration sealed with Joint Compound and the end of a 1-inch pipe sleave was not sealed. D.) The smoke wall by surgical services had a 1/4-inch unsealed gap around wires. E.) The smoke wall by room 315 had an unsealed 4-inch hole in the wall. F.) The smoke wall by room 309 had an unsealed 4-inch hole in the wall. G.) The smoke wall by room 209 had penetrations filled with Joint Compound. H.) The smoke wall by room 215 had a 5x6 inch area where the cement was broken leaving 1/8-inch cracks in the wall. I.) The OB lobby smoke wall had three unsealed 1/4-inch gaps around pipes. J.) The Pharmacy smoke wall had three unsealed 1/4-inch gaps around pipes and Joint Compound was used to seal penetrations. K.) The smoke wall by room A-286 had an unsealed 1/4-inch gap around a wire. L.) The smoke wall by Respiratory had an unsealed 1/4-inch gap around a wire. M.) The smoke wall by Hospitality Services had an unsealed 1-inch hole and Joint Compound was used to seal penetrations. Based on interview at the time of observation, the Facilities Supervisor, the Facilities Manager, and Director of Facilities agreed the aforementioned smoke barriers had unsealed penetrations or were sealed with material that did not meet ASTM E 814.	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 372	Continued From page 18 The findings were reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 372		
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff, visitors, and patients. Findings include: Based on records review with the Facilities Manager and the Safety Coordinator on 11/16/23 at 2:52 p.m., no documentation was available to show a second shift fire drill for the first quarter of 2023 was conducted. Based on interview at the	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 712	Continued From page 19 time of record review, the Safety Coordinator agreed the aforementioned drill was missed, and stated the facility has implement an audit system to ensure drills are not missed. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 712		
K 761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is not met as evidenced by: Based on observation, records review, and interview; the facility failed to ensure 1 of 3 smoke barrier doors on the 200-hall were routinely inspected and repaired as part of the facility maintenance program. This deficient practice could affect 10 patients in two smoke compartments. Findings include:	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 761	Continued From page 20 Based on observations with Facilities Supervisor and the Safety Coordinator on 11/16/23 at 1:30 p.m., one door leaf of the smoke doors by room 216 was damaged due to 12 small screw holes down the inner edge of the door leaf. Based on records review Between 1:00 p.m. and 3:00 p.m., the fire/smoke door testing form dated 11/14/23 indicated all smoke and fire doors passed inspection. Based on interview at the time of observation, the Facilities Supervisor stated the aforementioned smoke door contained small holes due to some type of astragal was removed at an unknown date. The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities, and the Safety Coordinator during the exit conference.	K 761		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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 other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 920	Continued From page 21 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 This STANDARD is not met as evidenced by: 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 or were daisy chained according to LSC/2012 chapter 19 and NFPA-70/2011, 400.8. This deficient practice could affect up to staff, visitors and 4 patients in two smoke compartments. Findings include: Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 between 10:00 a.m. and 3:00 p.m., the following areas had improper use of power strips: A.) A refrigerator and a microwave (high power draw equipment) were plugged into and supplied power by a power strip in the Physician Lounge. B.) A refrigerator and a coffee pot (high power draw equipment) were plugged into and supplied power by a power strip in the EVS lounge. C.) In the Bio-med Office a power strip was plugged into and supplied power by another power strip. Based on interview at the time of observations, the Facilities Manager agreed there were improper use of power strips. The finding was reviewed with the Facilities	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST** **AUBURN, IN 46706**

(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
K 920	Continued From page 22 Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities and the Safety Coordinator during the exit conference.	K 920		
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150045	A. BUILDING **01 - MAIN BLDG** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW DEKALB HOSPITAL	**1316 E SEVENTH ST AUBURN, IN 46706**

(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
K 923	Continued From page 23	K 923		

considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.
11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure 3 of 3 oxygen storage rooms were provided with a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED. This deficient practice could affect staff, visitors, and 5 patients.

Findings include:

Based on observations with Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, and the Safety Coordinator on 11/16/23 between 10:00 a.m. and 3:00 p.m., the Main oxygen storeroom, and the two respiratory storerooms were used as storage for oxygen cylinders. The doors to the rooms were not provided with precautionary signs which states "CAUTION: OXIDIZING GAS(ES) STORED." Based on interview at the time of observation, the Maintenance Director stated each storeroom did not have precautionary signs indicating storage of oxidizing gasses.

The finding was reviewed with the Facilities Supervisor, the Facilities Manager, Nursing Quality Specialist, Director of Facilities and the Safety Coordinator during the exit conference.