PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155516		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/05/2018		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 2200 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID	T	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.  Survey Date: 06/05/18  Facility Number: 001203 Provider Number: 155516 AIM Number: N/A  At this Emergency Preparedness survey, Parkview Memorial Hospital -CCC was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 41 and had a census of 32 at the time of this survey.  Quality Review completed on 06/08/18 - DA  The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:		E 00	000	Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for the statement of deficiencies. The plan of correction is prepared and/ or solely executed because it is required by the provisions of federal and state law.		
E 0015 SS=C Bldg			E 00	015	1. What corrective actions be taken- The Emergency Operations Annex 3 has been reviewed updated to include emergence lighting for disaster prepared was addressed with correction added 6/6/18. Disaster totes the unit were checked to ensure the addights and batteries were	Plan- and cy Iness ons s on	07/05/2018

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

storage of provisions; (B) Emergency lighting; (C)

TITLE

available to address emergency

(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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: S5CD21 Facility ID: 001203 If continuation sheet Page 1 of 6

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

PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155516		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  06/05/2018	
NAME OF PROVIDER OR SUPPLIER PARKVIEW MEMORIAL HOSPITAL-CCC		STREET ADDRESS, CITY, STATE, ZIF 2200 RANDALLIA DR FORT WAYNE, IN 46805	PCOD	
(X4) II PREFI TAG			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLETION
TAG	Fire detection, and (D) Sewag with 42 CFR 4 could affect all Findings included Based on record Preparedness C Administrator facility's Emergial of the Administrator of the general statement of the Facilities Direct are on the general with the general wi	extinguishing, and alarm systems; e and waste disposal in accordance 83.73(b)(1). This deficient practice occupants.  de:  d review with the Disaster oordinator, Facilities Director and on 06/05/18 at 11:15 a.m., the gency Preparedness plan provided the emergency lighting in an ane time of review. Based on time of records review, the tor and Administrator stated lights rator and there are flashlights but edness Coordinator stated that is	event. During this tim no emergency noted emergency totes wer not addressed in emprocedures. Education additional information member on Continuin Center Unit. Egress levacuation route is one ensure lighting is available in cemergency. Please sevacuation route is one ensure lighting is available in cemergency. Please sevacuation route is one ensure lighting for evacuation and issue since the Life Significant particular programments. The and has not been an issue since the Life Significant programments in the Annex regulations have been facilities have emerging lighting for evacuation generator. Staff education of totes and Operations Plan will with staff between 6/2 assure staff is aware information on the Engreparedness address in the event of evacuation emergency and location of the headlamps. To complete do y July, 5 Administrator or designificant complete one-on-one with all current staff of Operations Plan for each of the savailable in the emergency. Please severe in the event of ensure know what is available in the emergency. Please severes and the emergency. Please severes and the emergency of the emergency. Please severes and the emergency of the emergency of the emergency. Please severes and the emergency of the emergency of the emergency of the emergency of the emergency. Please severes and the emergency of the emergen	ne there was and re in place but ergency on for a given to staffing Care lighting of an generator to allable during on. cted others-affect to other re was not emergency exiewed other at to ensure en met. gency outside an route on the cation on Emergency be reviewed 6/18-7/5/18 to of additional mergency essing lighting lightin

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			l	COMPLETED	
155516			B. WING 06/05/2018				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					ANDALLIA DR		
PARKVIE	EW MEMORIAL HO	SPITAL-CCC		FURI	NAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	attachment (A) for staff sheek	off	DATE
					attachment (A) for staff check- on education.	·OTT	
					3. What measures will be p	ıŧ	
					into place to ensure this does		
					recur?		
					The Director of Emergency		
					Preparedness and Administra	tor	
					reviewed and revised as nece		
					to ensure the emergency light	-	
					in case of an emergency even	t	
					occurs. These revisions went		
					on 6/6/18. Administrator/desig		
					will review emergency tote box		
					during business hours Monday		
					through Friday 2 times a mont	n ior	
					2 months, then once a for 4 months.		
					4. How corrective actions w	ill	
					be monitored?		
					The Emergency Operations P	lan	
					Annex-3 will be reviewed on a		
					annual basis to assure		
					compliance with regulations.		
					Administrator/ designee will au		
					emergency totes for flashlights		
					headlamps and batteries. On		
					the audit tool is completed at t		
					6 month then the audit tool will reviewed in QAPI and by	i be	
					Administrator for trends to		
					determine if further education	or	
					monitoring is needed. See		
					attachment (B) for audit tool.		
					Date of compliance: July 5, 20	18	
E 0026							
0020							

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

Event ID:

S5CD21

Facility ID: 001203

If continuation sheet

Page 3 of 6

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/20/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPL	
155516			B. WING		06/05/2018	
NAME OF	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
		ACDITAL COC		RANDALLIA DR		
PARKVI	EW MEMORIAL HO	JSPITAL-CCC	FURT	WAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
Bldg	failed to ensure emand procedures includer a waiver declaccordance with seep provision of care are care site identified officials in accordant This deficient pract.  Findings include:  Based on record rever preparedness Coord Administrator on Offacility's Emergence did not address the waiver declared by review. Based on ir review, the Disaster stated developing the	view and interview, the facility ergency preparedness policies lude the role of the LTC facility lared by the Secretary, in ction 1135 of the Act, in the not treatment at an alternate by emergency management ince with 42 CFR 483.73(b)(8). Lice could affect all occupants.  View with the Disaster dinator, Facilities Director and 6/05/18 at 11:25 a.m., the y Preparedness plan provided role of the LTC facility under a the Secretary at the time of interview at the time of records ar Preparedness Coordinator the waver police is currently that it is not yet completed.	E 0026	1. What corrective actions we be taken- The Disaster Preparedness Coordinator has completed the waiver policy and it is now in place. See Attachment C- requesting Waiver 1135 2. Potential to affect others- Currently, there is no affect to other residents. There was not has not been an emergency sithe Life Safety audit. Waiver policy is complete and in place 3. What measures will be position place to ensure this does recur- Systematic review of the Waiver 1135 section was review and on an annual basis will be updated as needed to assure compliance with all requirement are being followed for Parkview Hospital and Continuing Care Center. Continuing Care Center. Continuing Care Center. Continuing Care has nine different Parkview location for any emergency the may require a need for patient be evacuated. 4. How corrective actions we be monitored- Administrator will check with Director of Emergency Preparedness to track any changes that may occur. An a to monitor availability of the waster to the continuity of the waster to the continuity of the waster to the continuity of the waster to make the property of	e  ot or ince e. ut not ne ewed s ents as as as at to to till	07/05/2018

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

Event ID:

S5CD21 Facility ID: 001203

If continuation sheet Page 4 of 6

will be once a month times 6 months. Once the 6 months are

PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		<del></del>	COMPLETED	
155516		B. WING 06/05/2018					
NAME OF PROVIDER OR SUPPLIER PARKVIEW MEMORIAL HOSPITAL-CCC			STREET ADDRESS, CITY, STATE, ZIP COD 2200 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		NO CHENNE N. L. C. GONDE GENERAL		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	· ·			TAG	DEFICIENCY)		DATE
					complete the audit tool will be reviewed in the QAPI meeting ensure compliance. See attachment (D) for waiver aud sheet.  5. Date of compliance: July 2018	to it	
K 0000							
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 06/05/18  Facility Number: 001203 Provider Number: 155516 AIM Number: N/A  At this Life Safety Code survey, Parkview Memorial Hospital - CCC was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  The fully sprinklered Parkview Memorial Hospital - CCC is located on the fifth floor in the 5 South and 5 South Extended Units of a 9 story hospital of Type I (332) construction with a basement. The facility has a fire alarm system with smoke		K 0	000	Preparation and / or execution this plan of correction does no constitute admission or agree by the provider of the truth of the facts alleged or conclusions so for the statement of deficiencies. The plan of correction is preparand/ or solely executed because required by the provisions of federal and state law.	ot ment the et es. ared se it	

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

Event ID:

\$5CD21 Facility ID: 001203

If continuation sheet Page 5 of 6

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

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(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	of this survey.  All areas where patients have customary access were sprinkled. All areas providing facility services were sprinkled  Quality Review completed on 06/08/18 - DA						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: S5CD21 Facility ID: 001203 If continuation sheet Page 6 of 6