

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 18, 19, 22, 23, and 24, 2013</p> <p>Facility number: 000419 Provider number: 155489 Aim number: 100273190</p> <p>Survey team: Karen Lewis, RN, TC Toni Maley, BSW Ginger McNamee, RN (July 18 and 19, 2013) Karen Koeberlein, RN (July 18 and 19, 2013) Tina Smith-Staats, RN (July 19, 2013) Betty Retherford, RN (July 22 and 23, 2013) Linn Mackey, RN (July 23 and 24, 2013)</p> <p>Census bed type: SNF/NF: 76 Residential: 8 Total: 84</p> <p>Census payor type: Medicare: 18 Medicaid: 46 Other: 20</p>	F000000	<p>This Plan of Correction is prepared and executed because it is required by the provision of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of August 23, 2013. Parker Health Care also respectfully requests paper compliance.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368		
(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	
	<p>Total: 84</p> <p>Residential Sample: 5</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368		
(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	
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain the residents' dignity while waiting for meals, while being fed and in regards to seating arrangements for 5 of 6 residents reviewed for dignity while dining (Residents #76, #60, #15, #3 and #9).</p> <p>Findings include:</p> <p>1.) During a 7/18/13, 11:40 a.m. to 12:20 p.m., South dining room lunch meal observation, the following was observed:</p> <p>Resident #3 was seated in a geri-chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and ate alone.</p> <p>At 11:40 a.m., dependent residents</p>	F000241	<p>1. Situation occurred in the past, unable to correct.2. All residents who have cognitive impairment have the potential to be affected.3. Staff in-serviced on how to maintain and/or enhance each resident's dignity and recognize their individuality. Hospice nurse and staff in-serviced on being seated while assisting resident with eating and in making eye contact with resident. Resident #3 still requires use of over-bed table, but has been moved closer to other residents. 4. DON/Designee will make dignity rounds in dining room daily times 2 weeks, weekly times 4 weeks, then monthly ongoing. Any concerns will be taken to QA committee for any action. 5. August 23, 2013.</p>	08/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>were seated in the dining room. They were facing the table and seated in a manner indicative of dining. No audio or visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were provided. The residents did not converse with one another. The staff did occasionally speak to the residents as they escorted residents into the dining area, but they didn't engage in a conversation.</p> <p>At 11:48 a.m., Activity Assistant #1 approached dependent residents one after the other, she showed them cards and talked about the pictures on the cards. She spent less than 1 minute talking to each resident. Residents #76, #60, #9 and #3 were each offered the card activity for 1 minute or less.</p> <p>From 11:40 a.m. to 12:00 p.m., more dependent residents were escorted by the staff into the dining room and assisted to sit at the dining tables. The only stimulation offered to any of the residents, who were escorted into the room, was the 1 minute card</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>activity.</p> <p>At 12:00 p.m., an announcement was made indicating meals were ready to be served in the South dining room. This practice resulted in a 20 minute pre-meal wait without being offered more than one minute of stimulation.</p> <p>2.) During a 7/22/13, 11:24 a.m. to 12:10 p.m., South dining room pre-lunch meal observation, the following was observed:</p> <p>Resident #3 was seated in a geri-chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and ate with the assistance of a speech therapist.</p> <p>At 11:24 a.m., dependent residents were seated in the dining room. They were facing the table and seated in a manner indicative of dining. No audio, visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were provided. Residents #76, #60,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013	
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368			
(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			
	<p>#15 and #3 were included in the group of dependent residents sitting in the dining room. The residents did not converse with one another. The staff did occasionally speak to the residents, as they escorted residents into the dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>No activities or diversions were offered prior to meal service at 12:01 p.m. This resulted in a 35 minute meal wait without offered stimulation or diversion.</p> <p>3.) During a 7/23/13, 11:25 a.m. to 12:00 p.m., lunch observation, the following was noted:</p> <p>Resident #3 was seated in a geri-chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and dined away from other residents.</p> <p>At 11:25 a.m., dependent residents were seated in the dining room. They</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013	
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368			
(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			
	<p>were facing the table and seated in a manner indicative of dining. No audio or visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were provided. Residents #76, #60, #15 and #3 were included in the group of dependent residents sitting in the dining room. The residents did not converse with one another. Staff did occasionally speak to residents, as they escorted residents into the dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>At 11:30 a.m., Activity Assistant #2 offered 1 minute of individual one to one interaction with cards to Residents #76, #60, #15 and #3. She offered 1 minute or less of an individualized one to one activity to each resident she interacted with in the room.</p> <p>At 12:03 p.m., the meal was served. This practice resulted in 38 minutes of waiting for a meal with only 1 minute of stimulation or diversion offered.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013	
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368			
(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			
	<p>Resident #9 was seated in her broad chair being fed her meal. Hospice Nurse #5 stood beside Resident #9 and fed her. This resulted in the Hospice nurse not making eye contact or looking the resident in the face during feeding. During a 7/23/14, 12:12 p.m. interview, Hospice Nurse #5 indicated she should have sat beside the resident while she fed her.</p> <p>4.) During a 7/23/13, 3:17 p.m., interview, Activity Assistant #2 indicated "5 Alive" was a sensory stimulation group offered in the South dining room before lunch. She indicated the activity lasts 1 to 2 minutes per resident. She indicated she showed residents cards and they talked about them.</p> <p>5.) During a 7/23/13, 4:10 p.m. interview, RN #3 indicated dependent residents were taken to the South dining room 20 to 30 minutes before meals where they would sit and chat with one another.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>6.) During a 7/23/13, 4:15 p.m., interview, CNA #4 indicated dependent residents were assisted to the South dining room 30 minutes before meals where they interacted with one another.</p> <p>7.) During a 7/24/13, 10:00 a.m., interview, the Director of Nursing (DoN) indicated Resident #3 was using an over-bed table to dine due to her fractured leg. The DoN additionally indicated that although Resident #3 needed an over-bed table there was no reason for her to be seated away from her peers. The DoN also indicated staff are required to sit and maintain eye contact when feeding residents. She indicated Hospice Nurse #5 had informed the DoN of her error while feeding.</p> <p>8.) During a 7/24/13, 10:03 a.m., interview, the Administrator indicated 30 minutes to sit at a table awaiting your meal was not an acceptable practice. She additionally indicated activities designed for residents with cognitive impairment should have substance and be meaningful to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>resident.</p> <p>9.) Resident # 75's record was reviewed on 7/24/13 on 9:25 a.m. Resident #75's current diagnoses included, but were not limited to, muscle weakness, dementia and depression.</p> <p>Resident #75, had a current, 6/26/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, understood others and was understood by others.</p> <p>10.) Resident #15's record was reviewed on 7/24/13 at 10:35 a.m. Resident #15's current diagnoses included, but were not limited to, dementia, depression and Alzheimer's disease.</p> <p>Resident #15, had a current, 5/13/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, sometimes understood others and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>was sometimes understood by others.</p> <p>11.) Resident #60's record was reviewed on 7/22/13 at 10:43 a.m. Resident #60's current diagnoses included, but were not limited to, anxiety, dementia and depression.</p> <p>Resident #60, had a current, 5/31/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, had minimum difficulty hearing, usually understood others and was sometimes understood by others.</p> <p>12.) Resident #3's record was reviewed on 7/24/13 at 11:13 a.m. Resident #3's current diagnoses included, but were not limited to, macular degeneration, depression, dementia and current fracture of the left leg.</p> <p>Resident #3, had a current, 7/8/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368		
(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	
	<p>had minimum hearing difficulty, was understood by others and understood others.</p> <p>13.) Resident #9's record was reviewed on 7/24/13 at 1:30 p.m. Resident #9's current diagnoses included, but were not limited to, dementia and anxiety. Resident #9 had a current, 8/7/12, order for hospice services.</p> <p>Resident #9 had a current, 11/14/12, care plan problem/need regarding needing assistance and encouragement to consume meals.</p> <p>Resident #9, had a current, 5/8/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions and required extensive assistance for eating.</p> <p>3.1-3(t)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013	
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368			
(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			
F000248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide meaningful activities for cognitively impaired dependent residents who attended "Five Alive" sensory stimulation activity for 5 of 5 residents reviewed for activity needs. (Residents #76, #60, #15, #3 and #67)</p> <p>Findings include:</p> <p>1.) During a 7/18/13, 11:40 a.m. to 12:20 p.m. South dining room lunch meal observation the following was observed:</p> <p>At 11:40 a.m., dependent residents were seated in the dining room. They were facing the table and seated in a manner indicative of dining. No audio or visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were</p>	F000248	<p>1. Situation occurred in past, unable to correct. 2. All residents who have cognitive impairment and are dependent have the potential to be affected.3. Activity staff in-serviced on providing meaningful activities for cognitive impaired, dependent residents. Establish activity program of visual and audio stimulation for cognitive impaired residents while awaiting meals.4. Administrator/Designee will observe dining room daily times 2 weeks, weekly times 4 weeks, then monthly ongoing that meaningful activities are being provided. Any concerns will be taken to QA committee for any action. 5. August 23, 2013.</p>	08/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>provided. The residents did not converse with one another. The staff did occasionally speak to the residents, as they escorted residents into the dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>At 11:48 a.m., Activity Assistant #1 approached dependent residents one after the other. She showed them cards and talked about the pictures on the cards. She spent less than 1 minutes talking to each resident. Residents #76, #60, #9, #67 and #3 were each offered the card activity for 1 minute or less.</p> <p>From 11:40 a.m. to 12:00 p.m., more dependent resident were escorted by the staff into the dining room and assisted to sit at the dining tables. The only stimulation offered to any of the residents who were escorted into the room was the 1 minute card activity.</p> <p>At 12:00 p.m. an announcement was made indicating meals were ready to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>be served in the South dining room. This resulted in a 20 minute pre-meal wait without being offered more than one minute of stimulation.</p> <p>2.) During a 7/22/13, 11:24 a.m. to 12:10 p.m. South dining room pre-lunch meal observation the following was observed:</p> <p>At 11:24 a.m., dependent residents were seated in the dining room. They were facing the table and seated in a manner indicative of dining. No audio or visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were provided. Residents #76, #60, #15, #3 and #67 were included in the group of dependent residents sitting in the dining room. The residents did not converse with one another. Staff did occasionally speak to residents, as they escorted residents into the dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>No activities or diversions were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>offered prior to meal service at 12:01 p.m. This resulted in a 35 minute pre-meal wait without being offered any stimulation or diversion.</p> <p>3.) During a 7/23/13, 11:25 a.m. to 12:00 p.m. lunch observation, the following was noted:</p> <p>Resident #3 was seated in a geri-chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and ate away from other residents.</p> <p>At 11:25 a.m., dependent residents were seated in the dining room. The were facing the table and seated in a manner indicative of dining. No audio, visual stimulation was offered. No manipulative devices, such as cards, magazines, puzzles or games were provided. Residents #76, #60, #15, #3 and #67 were included in the group of dependent residents sitting in the dining room. The residents did not converse with one another. Staff did occasionally speak to residents, as they escorted residents into the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>At 11:30 a.m., Activity Assistant #2 offered 1 minute of individual one to one interaction with cards to Residents #76, #60, #15, #3 and #67. She offered 1 minute or less of individualized one to one activity to each resident she interacted with in the room.</p> <p>At 12:03 p.m., the meal was served. (Resulting in 38 minutes of waiting for a meal with only 1 minute of stimulation or diversion offered).</p> <p>4.) During a 7/23/13, 3:17 p.m. interview, Activity Assistant #2 indicated "5 Alive" was a sensory stimulation group offered in the South dining room before lunch. She indicated the activity lasts 1 to 2 minutes per resident. She indicated she showed residents cards and they talked about them.</p> <p>5.) During a 7/23/13, 4:10 p.m.,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>interview, RN #3 indicated dependent residents were taken to the South dining room 20 to 30 minutes before meals where they could sit and chat with one another.</p> <p>6.) During a 7/23/13, 4:15 p.m., interview CNA #4 indicated dependent residents were assisted to the South dining room 30 minutes before meals where they interacted with one another.</p> <p>7.) During a 7/24/13, 10:00 a.m., interview, the Director of Nursing (DoN) indicated Resident #3 was using an over-bed table to dine due to her fractured leg. The DoN additionally indicated that although Resident #3 needed an over-bed table there was no reason for her to be seated away from her peers.</p> <p>During a 7/24/13, 10:03 a.m. interview, the Administrator indicated 30 minutes to sit at a table awaiting your meal was not an acceptable practice. She additionally indicated activities designed for residents with cognitive impairment should have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>substance and be meaningful to the resident.</p> <p>8.) Resident # 75's record was reviewed on 7/24/13 on 9:25 a.m. Resident #75's current diagnoses included, but were not limited to, muscle weakness, dementia and depression.</p> <p>Resident #75's, had a current, 7/10/13, care plan problem/need regarding the resident enjoying playing cards, being social, going to entertainment, and having a newspaper. Approaches to this problem included, but were not limited to, "encourage resident to attend group activities, encourage resident to socialize with others and engage resident with activities by talking, smiling and providing activity material."</p> <p>Resident #75 had a current, 7/23/13, care plan problem/need regarding depression and having little interest in being active. This problem originated 1/24/12. Approaches to this problem included, but were not limited to,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>"encourage resident to take an active roll in the facility and invite resident and provide assistance to activities of choice and interest."</p> <p>Resident #75, had a current, 6/26/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, understood others and was understood by others. The resident himself indicated it was very important to have books/reading materials, keep up on the news, attend his favorite activities, go outside, attend religious events and listen to music.</p> <p>Resident #75 had a current, 5/22/13, "Activity Update Assessment" which indicated the resident enjoyed group activities, liked to sing, enjoyed religious activities, was alert and oriented to person and could fall asleep in activities if not engaged.</p> <p>9.) Resident #15's record was reviewed on 7/24/13 at 10:35 a.m. Resident #15's current diagnoses included, but were not limited to,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>dementia, depression and Alzheimer's disease.</p> <p>Resident #15 had a current, 12/9/11, care plan problem/need regarding depression. Approaches to this problem included, but were not limited to, "encourage socialization and participation in leisure activities."</p> <p>Resident #15 had a current, 12/1/10, care plan problem/need regarding little or no activity involvement due to Alzheimer's disease. Approaches to this problem included, but were not limited to, "assist resident to and from activities and encourage the resident to attend group activities."</p> <p>Resident #15, had a current, 5/13/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, sometimes understood others and was sometimes understood by others.</p> <p>Resident #15 had a current, 5/11/13, "Activity Update Assessment" which indicated the resident was alert to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>person, needed reminders and cues, needed assistance to and from activities, enjoyed ball toss, music, exercise and sing-a-long.</p> <p>10.) Resident #60's record was reviewed on 7/22/13 at 10:43 a.m. Resident #60's current diagnoses included, but were not limited to, anxiety, dementia and depression.</p> <p>Resident #60 had a current, 3/8/13, care plan problem/need regarding depression and mood decline. Approaches to this problem included, but were not limited to, "encourage resident to attend group activities."</p> <p>Resident #60 had a current, 3/2/11, care plan problem/need regarding little to no activity attendance. Approaches to this problem included, but were not limited to, "engage resident in group activities by talking with her, touching her hand, and laughing at what she thinks was funny."</p> <p>Resident #60, had a current, 5/31/13, significant change, Minimum</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, had minimum difficulty hearing, usually understood others and was sometimes understood by others. During this assessment, her family indicated it was very important to the resident to hear music, keep up to date on the news, be involved in groups, participate in her favorite activities and attend religious events.</p> <p>Resident #60 had a current, 5/31/13, "Activity Update Assessment" which indicated she was alert at times but seemed to sleep a lot, needed assistance to and from activities, and activity staff were to try to make sure the resident got out of her room as often as possible.</p> <p>Resident #60 had a current, 6/8/13, "Activity Interest Survey" which indicated the resident enjoyed: going outdoors, people watching, entertainment, holiday events, church services, prayer, music and TV movies.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013	
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368			
(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			
	<p>During a 7/18/13, 12:37 p.m., interview, Resident #60's family indicated she would like Resident #60 in activities and involved with others.</p> <p>11.) Resident #3's record was reviewed on 7/24/13 at 11:13 a.m. Resident #3's current diagnoses included, but were not limited to, macular degeneration, depression, dementia and current fracture of the left leg.</p> <p>Resident #3 had a current, 6/7/11, care plan problem/need regarding enjoying cognitively stimulating events such as reading, doing word searches and bingo. Approaches to this problem included, but were not limited to, "engage resident in group activities by talking to her and helping with activity material and help resident get books, newspaper, or word searches as needed."</p> <p>Resident #3 had a current, 6/17/13, care plan problem/need regarding her having anxiety and confusion and calling out. Approaches to this problem included, but were not limited</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368		
(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	
	<p>to, "redirect resident with an activity."</p> <p>Resident #3, had a current, 7/8/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, had minimum hearing difficulty, was understood by others and understood others. During this assessment, her family indicated it was very important to the resident to be involved in religious events and somewhat important to listen to music, keep up on the news, attend groups events and participate in her favorite activities.</p> <p>Resident #3 had a current, 7/2/13, "Activity Update Assessment" which indicated the resident was alert to person and place, "loves bingo, enjoys church, exercise, parties, and entertainment."</p> <p>12.) Resident #67's record was reviewed on 7/24/13 at 1:55 p.m. Resident #67's current diagnoses included, but were not limited to, dementia, depression and anxiety.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>Resident #67 had a current, 6/9/11, care plan problem/need regarding enjoying coming to activities and history of uncontrollable crying. Approaches to this problem included, but were not limited to, "engage resident in group activities and redirect resident with an activity if she was crying."</p> <p>Resident #67, had a current, 7/17/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions, sometimes understood others and was sometimes understood by others.</p> <p>During a 2/20/13, most current, full, MDS assessment, her family indicated it was very important to the resident to have books/reading material, keep up on news, attend group events, go outdoors, participate in her favorite activities and listen to music.</p> <p>Resident #67 had a current, 7/15/13, "Activity Update Assessment" which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>indicated the resident was oriented to person, attended theme parties, bingo with her family, ball toss, sing-a-long, devotions and news.</p> <p>During a 7/18/13, 11:08 a.m. interview, Resident #67's family indicated they would like her in activities and not sitting by herself in her wheelchair in her bedroom.</p> <p>13.) A 7/23/13, untitled facility document, which was provided by the RN consultant on 7/24/13 at 9:25 a.m., indicated Residents #76, #60, #15, #3, #9 and #67 were cognitively impaired and dependent on staff assistance for mobility.</p> <p>3.1-33(c) 3.1-33(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368		
(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	
F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on, observation, record review and interview, the facility's Quality Assessment and Assurance Committee failed to develop and implement plans of action to ensure dignified dining experiences and meaningful activities for cognitively impaired residents were provided. (Resident #'s 76, 60, 15, 3, 9, and 67)</p> <p>Findings include:</p>	F000520	<p>1. Concerns with dignity and respect of cognitive impaired residents during dining experience and failure to provide meaningful activities while cognitive impaired residents await meals in the dining room was taken to QA committee for action.</p> <p>2. All residents who are cognitive impaired have the potential to be affected. 3. All staff in-serviced on the role of QA committee.4. QA committee will review monthly action plans and audits for dignity and providing meaningful</p>	08/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>1.) During a 7/18/13, 11:40 a.m. to 12:20 p.m. South dining room lunch meal observation the following was observed:</p> <p>At 11:48 a.m. on 7/18/13, Activity Assistant #1 approached dependent residents one after the other, she showed them cards and talked about the pictures on the cards. She spent less than 1 minutes talking to each resident. Residents #76, #60, #9 and #3 were each offered the card activity for 1 minute or less. Resident # 3 was positioned at an overbed table by herself.</p> <p>At 12:00 p.m. an announcement was made indicating meals were ready to be served in the South dining room. This practice resulting in a period of 20 minutes pre-meal wait without being offered more than one minute of stimulation.</p> <p>2.) During a 7/22/13, 11:24 a.m. to 12:10 p.m. South dining room pre-lunch meal observation the</p>		<p>activities during dining experience until compliance is established and then as needed. Any concerns will be addressed.5. August 23, 2013.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>following was observed: Resident #3 was seated in a geri -chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and ate with the assistance of a speech therapist.</p> <p>Residents #76, #60, #15 and #3 were included in the group of dependent residents sitting in the dining room. The residents did not converse with one another. Staff did occasionally speak to residents as the escorted residents into the dining area, but they didn't engage in a conversation. Resident #67's family member sat beside her as she waited.</p> <p>No activities or diversions were offered prior to meal service at 12:01 p.m. This resulted in a period of 35 minutes meal wait without being offered any stimulation or diversion.</p> <p>3.) During a 7/23/13, 11:25 a.m. to 12:00 p.m. lunch observation the following was noted:</p> <p>Resident #3 was seated in a geri</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>-chair at an over-bed table. She was seated away from all other residents beside a table located at the exit door. She was served her meal and ate away from other residents.</p> <p>At 11:30 a.m., Activity Assistant #2 offered 1 minute of individual one to one interaction with cards to Residents #76, #60, #15 and #3. She offered 1 minute or less individualized one to one activity to each resident she interacted to in the room.</p> <p>At 12:03 p.m., the meal was served. This practice resulted in 38 minutes of waiting for a meal with only 1 minute of stimulation or diversion offered.</p> <p>4.) Resident #9 was seated in her broada chair being fed her meal during the observation on 7/23/13 from 11:25 a.m. to 12 noon. Hospice Nurse #5 stood beside Resident #9 and fed her. This resulted in the Hospice nurse not making eye contact or looking the resident in the face during feeding. During a 7/23/13, 12:12 p.m. interview, Hospice Nurse #5 indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>should have sat beside the resident while she fed her.</p> <p>5.) During a 7/23/13, 3:17 p.m., interview, Activity Assistant #2 indicated "5 Alive" was a sensory stimulation group offered in the South dining room before lunch. She indicated the activity lasts 1 to 2 minutes per resident. She indicated she showed the residents cards and they talked about them.</p> <p>6.) During a 7/23/13, 4:10 p.m., interview, RN #3 indicated dependent residents were taken to the South dining room 20 to 30 minutes before meals where they sit and chat with one another.</p> <p>7.) During a 7/24/13, 10:00 a.m., interview, the Director of Nursing (DoN) indicated Resident #3 was using an over-bed table to dine due to her fractured leg. The DoN additionally indicated that although Resident #3 needed an over-bed table there was no reason for her to be seated away from her peers. The DoN also indicated staff are required</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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
	<p>to sit and maintain eye contact when feeding residents. She indicated Hospice Nurse #5 had informed the DoN of her error while feeding.</p> <p>8.) During a 7/24/13, 10:03 a.m., interview, the Administrator indicated 30 minutes to sit at a table awaiting your meal was not an acceptable practice. She additionally indicated activities designed for residents with cognitive impairment should have substance and be meaningful to the resident.</p> <p>9.) During an interview with the Administrator on 7/24/13 at 4:52 p.m., she indicated the facility had failed to identify the concerns with dignified dining experiences and meaningful activities for cognitively impaired residents. She further indicated the facility had never reviewed the dining experiences and activities for cognitively impaired residents in the quality assurance committee.</p> <p>3.1-52(b)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKER HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 359 RANDOLPH ST PARKER CITY, IN 47368
--	---

(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