

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00195233.</p> <p>Complaint IN00195233 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 & F333.</p> <p>Survey date: March 14, 2016</p> <p>Facility number: 000468 Provider number: 155378 AIM number: 100290270</p> <p>Census bed type: SNF/NF: 103 Total: 103</p> <p>Census payor type: Medicare: 10 Medicaid: 75 Other: 18 Total: 103</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on March 18, 2016.</p>	F 0000	<p>The facility requests that this plan of correction be considered it's credible allegation of compliance. 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 forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</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: 155378		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2016	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052			
(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			
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to administer medication according to physician orders for 2 of 3 residents reviewed for physician orders(Residents B and C).</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 03/14/16 at 10:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, and coronary artery disease. Resident B did not have a diagnosis of heart failure or irregular heart rhythm.</p> <p>The MARs (Medication Administration Record) for December 2015 and January 2016 were reviewed. The MAR for December contained an entry, dated 12/30/15, which indicated Digoxin (helps make the heart beat stronger and with a more regular rhythm) 125 microgram tablet - take one tablet by mouth daily for atrial fibrillation (a condition involving irregular heart rhythm). The entry was continued on the January 2016 MAR. Resident B received 26 doses of Digoxin</p>	F 0282	<p>1. How will the corrective action(s) be accomplished for those residents found to be affected by the same deficient practice?</p> <p>Medication for Resident B was discontinued, the attending physician and the responsible party were notified. Nurse practitioner assessed Resident B at time medication was stopped and determined there was no adverse effects noted from medication.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>1. 100% Auditing of all medication orders with EZ MAR verification to ensure accuracy of transcription.</p>	04/13/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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>between December 30, 2015 and January 25, 2016.</p> <p>A written physician order for Digoxin could not be located for Resident B.</p> <p>A Physician's Order Sheet, dated 1/1/16 to 1/31/16, was reviewed and signed by the nurse practitioner on 1/26/16. The order sheet contained the 12/30/15 entry for Digoxin. The nurse practitioner crossed out the diagnosis of atrial fibrillation and indicated, "No." The nurse practitioner also crossed out Digoxin and indicated, "Not on list."</p> <p>A Physician's Order, signed by the nurse practitioner on 1/26/16, indicated discontinue Digoxin.</p> <p>During an interview on 3/14/16 at 3:40 p.m., RN #1 indicated the order for Digoxin was not on Resident B's admission orders and she did not see a physician's order to begin Digoxin in the clinical record.</p> <p>During an interview on 3/14/16 at 4:05 p.m., RN #2 indicated physician orders were entered into the computer by nursing staff. She indicated all orders were also hand written on physician order sheets and reviewed by the unit manager. A copy was placed in the resident's chart and signed by the physician or nurse practitioner.</p>		<p>2. Immediate competency training for all licensed staff</p> <p>3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur?</p> <p>1. All licensed personnel re-educated on the following:</p> <ul style="list-style-type: none"> * Medication transcription, EZ MAR processes and procedures and 2nd nurse verification of all new orders. * Physician's orders (At a Glance), * Medication reconciliation, * Medication Orders * Medication Administration * Medication administration competencies * "8 Rights of Medication Administration" <p>2. Nursing administration in serviced on proper verification of month end</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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 an interview on 3/14/16 at 4:15 p.m., Resident B indicated she did not have a history of any heart problems, but was mistakenly placed on Digoxin for a period of time. She indicated she did not know she was taking the medication at the time because she just took what was handed to her. Resident B indicated her husband had been taking Digoxin and she believed something was accidentally mixed up.</p> <p>2. The record of Resident C was reviewed on 3/14/16 at 11:30 a.m. Diagnoses included, but were not limited to, Atrial fibrillation, congestive heart failure, and hypertension.</p> <p>A Physician's Order, dated 10/17/2014 indicated Digoxin 0.125 milligram tablet. Give one tablet by mouth three times a week on Monday, Wednesday, and Friday for tachycardia. This order remained in effect through 12/29/15.</p> <p>The MARs from September 2015 through January 2016 were reviewed. The MARs indicated Resident C received Digoxin only one day per week from 09/01/15 through 12/21/15.</p> <p>During an interview on 3/14/16 at 11:45 a.m., LPN #3 indicated the computer</p>		<p>Physician orders.</p> <p>3. Administrative nurses will bring a copy of Physician order sheets to daily clinical meeting to verify all telephone orders were transcribed into EZ MAR correctly.</p> <p>4. Weekend Nursing supervisor/designee will perform chart audits of all new admissions from Friday through Sunday to ensure that admitting medications are reconciled and transcribed correctly</p> <p>4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?</p> <p>1. All new admission and new orders will be brought to morning meeting daily to be reviewed by the IDT clinical management team.</p> <p>2. The charge nurses will verify all</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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>displayed the medications due for each resident and this was how she knew what time and day to give each resident their medications.</p> <p>During an interview on 03/14/16 at 3:00 p.m., RN #1 indicated Resident C received Digoxin one time per week rather than three times per week as ordered, according to his clinical record. RN #1 indicated she could not find a physician's order or a reason the administration occurred in that way.</p> <p>During an interview on 3/14/16 at 4:05 p.m., RN #2 indicated the nurse who entered the order into the computer was the one who was responsible to enter the dosage and days or times for administration based on the physician order. If an order was not entered correctly, it would not show on the medication screen for the nurse to administer.</p> <p>During an interview on 3/14/16 at 4:25 p.m., the Nurse Consultant indicated the DON (Director of Nursing) who was in place during the time of the incidents regarding Residents B and C was no longer with the facility. The current clinical staff were unaware of the situations and were unable to find or provide any additional information.</p>		<p>orders were transcribed correctly into EZ MAR.</p> <p>3. DON/Designee to audit all physician orders daily x 2 weeks; then 3 times weekly x weeks; then randomly weekly x 4 weeks and report findings to QAPI commit x 3 months or until 100% compliance is achieved. to preform random checks to ensure integrity of order transcription.</p> <p>4. IDT team will meet at least weekly x4 weeks to monitor current QAPI to validate progress and assure compliance until substantial compliance is achieved.</p> <p>5. DON to complete random recap/rewrite audits at the end of the month.</p> <p>6. Pharmacy consultant to send monthly recommendations to the DON, DON to review the recommendations and complete.</p> <p>7. Pharmacy to complete a building wide audit.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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
F 0333 SS=D Bldg. 00	<p>An undated policy titled "Physician Orders," provided by RN #1 on 3/14/16 at 3:55 p.m., indicated, "...Nurse receiving order is responsible for complete order documentation and communication to pharmacy...Medications placed in EZMAR for specific resident by designated Nurse...including dosage, medication, route and frequency of administration, stop time & qualifying diagnosis...DON or designate reviews EZMAR and chart for new order accuracy...."</p> <p>This Federal tag relates to complaint IN00195233.</p> <p>3.1-35(g)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility administered medication without physician orders for 1 of 3 residents reviewed for physician orders (Resident B). The facility also failed administer medication in accordance with physician orders for 1 of 3 residents reviewed for physician orders (Resident C).</p>	F 0333	<p>8. Nurse that completed transcription error to complete 2 hour competencies with SDC</p> <p>9. Obtain employee files on every employee involved and review. Competencies will be given to those employees</p> <p>10. Re-examine double check process, re-educate 100% staff on process.</p> <p>1. How will the corrective action(s) be accomplished for those residents found to be affected by the same deficient practice? Medication for Resident B was discontinued, the attending physician and the responsible party were notified. Nurse practitioner assessed Resident B at time medication was stopped and determined</p>	04/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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>Findings include:</p> <p>1. The record of Resident B was reviewed on 03/14/16 at 10:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, and coronary artery disease. Resident B did not have a diagnosis of heart failure or irregular heart rhythm.</p> <p>The MARs (Medication Administration Record) for December 2015 and January 2016 were reviewed. The MAR for December contained an entry, dated 12/30/15, which indicated Digoxin (helps make the heart beat stronger and with a more regular rhythm) 125 microgram tablet - take one tablet by mouth daily for atrial fibrillation (a condition involving irregular heart rhythm). The entry was continued on the January 2016 MAR. Resident B received 26 doses of Digoxin between December 30, 2015 and January 25, 2016.</p> <p>A written physician order for Digoxin could not be located for Resident B.</p> <p>A Physician's Order Sheet, dated 1/1/16 to 1/31/16, was reviewed and signed by the nurse practitioner on 1/26/16. The order sheet contained the 12/30/15 entry for Digoxin. The nurse practitioner crossed out the diagnosis of atrial</p>		<p>there was no adverse effects noted from medication. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? 1. 100% Auditing of all medication orders with EZ MAR verification to ensure accuracy of transcription. 2. Immediate competency training for all licensed staff 3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur? 1. All licensed personnel re-educated on the following: * Medication transcription, EZ MAR processes and procedures and 2nd nurse verification of all new orders. * Physician's orders (At a Glance), * Medication reconciliation, * Medication Orders * Medication Administration * Medication administration competencies * "8 Rights of Medication Administration" 2. Nursing administration in serviced on proper verification of month end Physician orders. 3. Administrative nurses will bring a copy of Physician order sheets to daily clinical meeting to verify all telephone orders were transcribed into EZ MAR correctly. 4. Weekend Nursing supervisor/designee will perform chart audits of all new admissions from Friday through Sunday to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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>fibrillation and indicated, "No." The nurse practitioner also crossed out Digoxin and indicated, "Not on list."</p> <p>A Physician's Order, signed by the nurse practitioner on 1/26/16, indicated discontinue Digoxin.</p> <p>During an interview on 3/14/16 at 3:40 p.m., RN #1 indicated the order for Digoxin was not on Resident B's admission orders and she did not see a physician's order to begin Digoxin in the clinical record.</p> <p>During an interview on 3/14/16 at 4:15 p.m., Resident B indicated she did not have a history of any heart problems, but was mistakenly placed on Digoxin for a period of time. She indicated she did not know she was taking the medication at the time because she just took what was handed to her. Resident B indicated her husband had been taking Digoxin and she believed something was accidentally mixed up.</p> <p>2. The record of Resident C was reviewed on 3/14/16 at 11:30 a.m. Diagnoses included, but were not limited to, Atrial fibrillation, congestive heart failure, and hypertension.</p> <p>A Physician's Order, dated 10/17/2014</p>		<p>ensure that admitting medications are reconciled and transcribed correctly</p> <p>4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?</p> <p>1. All new admission and new orders will be brought to morning meeting daily to be reviewed by the IDT clinical management team. 2. The charge nurses will verify all orders were transcribed correctly into EZ MAR. 3. DON/Designee to audit all physician orders daily x 2 weeks; then 3 times weekly x weeks; then randomly weekly x 4 weeks and report findings to QAPI commit x 3 months or until 100% compliance is achieved. to preform random checks to ensure integrity of order transcription. 4. IDT team will meet at least weekly x4 weeks to monitor current QAPI to validate progress and assure compliance until substantial compliance is achieved. 5. DON to complete random recap/rewrite audits at the end of the month. 6. Pharmacy consultant to send monthly recommendations to the DON, DON to review the recommendations and complete. 7. Pharmacy to complete a building wide audit. 8. Nurse that completed transcription error</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
----------------------------------------------------------------------	-------------------------------------------------------------------------------

(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 Digoxin 0.125 milligram tablet. Give one tablet by mouth three times a week on Monday, Wednesday, and Friday for tachycardia. This order remained in effect through 12/29/15.</p> <p>The MARs from September 2015 through January 2016 were reviewed. The MARs indicated Resident C received Digoxin only one day per week from 09/01/15 through 12/21/15.</p> <p>During an interview on 03/14/16 at 3:00 p.m., RN #1 indicated Resident C received Digoxin one time per week rather than three times per week as ordered, according to his clinical record. RN #1 indicated she could not find a physician's order or a reason the administration occurred in that way.</p> <p>During an interview on 3/14/16 at 4:25 p.m., the Nurse Consultant indicated the DON (Director of Nursing) who was in place during the time of the incidents regarding Residents B and C was no longer with the facility. The current clinical staff were unaware of the situations and were unable to find or provide any additional information.</p> <p>This Federal tag relates to complaint IN00195233.</p>		<p>to complete 2 hour competencies with SDC 9. Obtain employee files on every employee involved and review. Competencies will be given to those employees 10. Re-examine double check process, re-educate 100% staff on process.</p>	

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

PRINTED: 04/06/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052		
(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	
	3.1-48(c)(2)				