

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946
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(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
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 8, 9, 10,11,12, 15 and 16, 2015</p> <p>Facility number: 000539 Provider number: 155746 AIM number: 100267280</p> <p>Census bed type: SNF: 1 SNF/NF: 38 Residential: 16 Total: 55</p> <p>Census payor type: Medicare: 6 Medicaid: 22 Other: 11 Total: 39</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in the requirements of participation or that the corrective action was necessary We are</p>	
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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.

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop a care plan with interventions to prevent further bruising for an at risk resident for 1 of 18 residents reviewed for care plans. (Resident #7)</p> <p>Finding includes:</p> <p>On 6/9/15 at 9:32 a.m., Resident #7 was observed to have dark purple</p>	F 0279	<p>requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date</p> <p>1.Immediate action for residentidentified: Res #7 had no ill effect from the deficiency cited. Full bodyassessment completed on Res #7 6/10/2015 and no further discoloration noted anddiscoloration noted in citation previously documented. Care plan for resident#7 reviewed and delicate skin care-plan added.</p> <p>2.How facility will identify otherresidents: Full body assessment done on all nursing</p>	06/30/2015

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	<p>discolorations to the back of both hands and wrist areas.</p> <p>Resident #7's record was reviewed on 6/9/15 at 3:20 p.m. Diagnoses included, but were not limited to, senile dementia, dysphagia, skin disorders, history of falls, urinary incontinence, and depressive disorder.</p> <p>Review of events charting indicated Resident #7 had multiple skin-related issues such as bruising and skin tears documented, including a bruise to the right outer wrist noted on 5/6/15 and a bruise to the back of the left hand noted on 5/18/15.</p> <p>Review of Resident #7's care plans indicated no care plan was present to indicate the resident was at risk for skin impairment or to put interventions in place to prevent further bruising or skin impairment.</p> <p>Interview with RN #1 on 6/9/15 at 4:00 p.m., indicated Resident #7's skin bruised easily and she had history of many bruises on her hands due to self propelling her wheelchair.</p> <p>Interview with the DON (Director of Nursing) on 6/10/2015 at 10:20 a.m., indicated Resident #7 did frequently have</p>		<p>residents completed 6/10/15with events done for any resident noted with discoloration and MD and familynotified per policy. Previous events for residents found to have discolorationsreviewed for patterns in discoloration. Care-plan audit and addition ofdelicate skin care-plans.</p> <p>3.System changes: Addition of care-planof fragile skin added to nursing residents. The care-plan with have residentspecific interventions added to those residents noted to have a pattern indiscoloration. For example: Resident is known to hit hands when enteringdoorways, Resident is known to look through belongings in drawers and closetsand has been noted to cause discoloration on hands and forearms. All staffin-service on 6/30/2015 for elder skin including: high risk for bruising, skinchanges in elderly, preventing and reporting bruising. Nursing staffin-serviced on 6/30/2015 for implementation of the delicate skin care planaddition to residents with resident specific interventions for known patternsin discoloration.</p> <p>4.How corrective action will bemonitored: For one month on a weekly basis the DON or designee will randomlypick 3 residents and complete a full body assessment checking for any bruising, followed by checking for a pattern in previously</p>		

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F 0282 SS=D Bldg. 00	<p>bruising to her hands and knees due to documented behaviors.</p> <p>The DON was interviewed on 6/10/15 at 1:57 p.m. regarding known bruising and skin issues for Resident #7 with no care plan or documented interventions. The DON indicated episodic care plans were done for skin tears, and pressure, but not bruising. She further indicated interventions for known risk conditions would normally be put in a care plan. The DON also indicated care plans were updated with each Quarterly MDS (Minimum Data Set) assessment and the most recent for Resident #7 was completed on 5/26/15, after Resident's current bruises were documented.</p> <p>On 6/10/15 at 2:40 p.m., the DON indicated the MDS coordinator just updated Resident #7's care plans to include delicate skin. The CNAs group sheets containing resident information were also updated to include delicate skin in addition to adding an alert to the resident's computer profile</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>		<p>documented bruises. An audit will then be completed on events being completed for noted discolorations and care-plan audit for specific interventions added to delicate skin care-plan for patterns noted. When 100% compliance is met for 4 consecutive weeks the DON or designee will randomly choose 3 residents and complete full body assessment once monthly checking for any bruising, followed by checking for a pattern in previously documented bruises. An audit will then be completed on events being completed for noted discolorations and care-plan audit for specific interventions added to delicate skin care-plan for patterns noted. When 100% compliance is met for 3 consecutive months the Quality Assurance committee will then decide on further monitoring need and frequency. Monthly reports will be provided to the committee for review.</p>		

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	<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 observation, record review, and interview, the facility failed to ensure a care plan was followed as written related to skin discolorations not assessed and monitored for 1 of 3 resident's reviewed for skin (non-pressure related), of the 4 who met the criteria for skin (non-pressure related). (Resident #2)</p> <p>Finding includes:</p> <p>On 6/8/15 at 11:35 a.m., Resident #2 was observed sitting in a wheelchair wearing a short sleeved top. The resident was observed to have a dark purple discoloration to the top of her left forearm. At the time of the observation the resident indicated she thought the discoloration was from a blood draw. She further indicated the area was tender if she touched it.</p> <p>On 6/9/15 at 1:45 p.m., Resident #2 was observed sitting in a wheelchair wearing a short sleeved top. The resident was observed to have a dark purple discoloration to the top of her left forearm.</p> <p>Record review for Resident #2 was completed on 6/9/15 at 3:19 p.m. The</p>	F 0282	<p>1.Immediate action for residentidentified: Res #2 had no ill effect from the deficiency cited. Care-plan andtreatments reviewed for resident. Head to toe assessment completed 6/9/2015 onresident. Bruise event completed for resident on 6/9/2015 for bruise noted incitation. MD and family notified.</p> <p>2. How facility will identify other residents:Full body skin assessments completed for all nursing residents during bathing,AM, and PM care to check for discoloration completed 6/10/2015.</p> <p>3.System change: Lab draw sheetmodified to include site of lab draw. Lab draw sheet modified to include nursefollow-up in 24 hours to check for discoloration. All nurses, medical recordsdirector that completes lab sheets, and lab draw nurse in-serviced 6/24/2015 onchange in lab draw sheets, and the procedure for follow-up to lab, to check for discoloration.</p> <p>4.How the corrective action will bemonitored: For one month on a weekly basis the DON or designee will audit that labdraw sheets have been completed accurately, checking the resident lab draw sitefor discoloration, and</p>	06/30/2015

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	<p>resident's diagnoses included, but were not limited to, dementia, atrial fibrillation, and hypertension.</p> <p>A care plan dated 6/24/14, indicated: Nursing: Resident was at risk for skin breakdown. Approach included to report any signs of skin breakdown (sore, tender, red, or broken areas).</p> <p>A Nursing Note dated 5/26/15 at 1:09 p.m., indicated the resident had blood work drawn from the left antecubital (front part of elbow) x 2 attempts. Review of the Nursing Notes from 5/26/15 to 6/3/15 lacked any indication of a discoloration to the residents left forearm.</p> <p>Interview with CNA #1 on 6/9/15 at 3:54 p.m., indicated she had transferred the resident on and off the toilet earlier that day. The CNA indicated the resident also needed assistance with dressing. She further indicated she was unaware the resident had a discoloration to her left forearm.</p> <p>Interview with LPN #1 on 6/9/15 at 3:59 p.m., indicated resident skin assessments were completed by the CNAs during bathing. If anything was observed the nurse would be notified to assess the area. The nurse indicated he was</p>		<p>then checking for event completion if discoloration noted. When 100% compliance is met for 4 consecutive weeks the DON or designee will complete every 2 weeks audit that lab draw sheets have been completed accurately, checking the resident lab draw site for discoloration, and then checking for event completion if discoloration noted. When 100% compliance is met for 2 consecutive audits the DON or designee will complete a monthly audit that lab draw sheets have been completed accurately, checking the resident lab draw site for discoloration, and then checking for event completion if discoloration noted. When 100% compliance met for 3 consecutive months the Quality Assurance committee will then decide on further monitoring need and frequency. Monthly reports will be provided to the committee for review.</p>	

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F 0309 SS=D Bldg. 00	<p>unaware the resident had a discoloration to the left forearm. He further indicated the resident needed assistance with toileting and dressing and the CNAs should have noticed the discoloration and told the nurse.</p> <p>Interview with the DON (Director of Nursing) on 6/9/15 at 4:13 p.m., indicated the resident had a blood draw on 5/26/15 from the left antecubital area. The DON indicated when a discoloration was found an Event would be initiated in the computer and the discoloration would be monitored until the area had healed. She further indicated there was not a Nursing Note or an Event Report completed of the discoloration and the staff should have observed the discoloration by now and assessed and documented the area.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>			

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	<p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions. (Resident #2)</p> <p>Finding includes:</p> <p>On 6/8/15 at 11:35 a.m., Resident #2 was observed sitting in a wheelchair wearing a short sleeved top. The resident was observed to have a dark purple discoloration to the top of her left forearm. At the time of the observation the resident indicated she thought the discoloration was from a blood draw. She further indicated the area was tender if she touched it.</p> <p>On 6/9/15 at 1:45 p.m., Resident #2 was observed sitting in a wheelchair wearing a short sleeved top. The resident was observed to have a dark purple discoloration to the top of her left forearm.</p> <p>Record review for Resident #2 was completed on 6/9/15 at 3:19 p.m. The resident's diagnoses included, but were</p>	F 0309	<p>1.Immediate action for residentidentified: Res #2 had a full body skin assessment done 6/9/2015. Discolorationto LFA noted in citation documented in skin event, and MD and family notifiedper policy. Res #2 had no ill effects from deficiency sited.</p> <p>2.How the facility will identify otherresidents: Full body skin assessments completed on all nursing resident, anydiscolorations not previously document were documented and MD and family werenotified per policy. Assessments and notification completed on 6/10/2015.</p> <p>3.System Changes: All staff in-servicedon elder skin including: high risk for bruising, skin changes in elderly, andpreventing and reporting bruises. In-service also included implementing newcare-plan for delicate skin for all nursing residents with specificindividualized interventions for known causes of bruising for the resident. Forexample: Resident is known to hit hands when going through doorways, residentis known to go through items in drawers and hit hands and forearms. Allin-services completed 6/30/2015.</p> <p>4.How corrective action will bemonitored: For one month on a weekly basis the DON or designee will randomlypick 3 residents and complete a full body assessment checking for</p>	06/30/2015	

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	<p>not limited to, dementia, atrial fibrillation, and hypertension.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 3/24/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 6 which indicated the resident was cognitively impaired. The assessment indicated the resident needed limited assistance of 1 person with bed mobility, transfers, walking, locomotion, dressing, toileting, and personal hygiene.</p> <p>A care plan dated 6/24/14, indicated: Nursing: Resident was at risk for skin breakdown. Approach included to report any signs of skin breakdown (sore, tender, red, or broken areas).</p> <p>A Nursing Note dated 5/26/15 at 1:09 p.m., indicated the resident had blood work drawn from the left antecubital (front part of elbow) x 2 attempts. Review of the Nursing Notes from 5/26/15 to 6/3/15 lacked any indication of a discoloration to the residents left forearm.</p> <p>Review of Bath Sheets from 6/1/15 to current indicated the resident did not have any skin issues.</p> <p>Review of Events from 5/26/15 to current</p>		<p>any bruising, followed by checking for a pattern in previously documented bruises. An audit will then be completed on events being completed for noted discolorations and care-plan audit for specific interventions added to delicate skin care-plan for patterns noted. When 100% compliance is met for 4 consecutive weeks the DON or designee will randomly choose 3 residents and complete full body assessment on a monthly basis checking for any bruising, followed by checking for a pattern in previously documented bruises. An audit will then be completed on events being completed for noted discolorations and care-plan audit for specific interventions added to delicate skin care-plan for patterns noted. When 100% compliance is met for 3 consecutive months the Quality Assurance committee will then decide on further monitoring need and frequency. Monthly reports will be provided to the committee for review.</p>	

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	<p>lacked an Event Report for the discoloration.</p> <p>Interview with CNA #1 on 6/9/15 at 3:54 p.m., indicated she had transferred the resident on and off the toilet earlier that day. The CNA indicated the resident also needed assistance with dressing. She further indicated she was unaware the resident had a discoloration to her left forearm.</p> <p>Interview with LPN #1 on 6/9/15 at 3:59 p.m., indicated resident skin assessments were completed by the CNAs during bathing. If anything was observed the nurse would be notified to assess the area. The nurse indicated he was unaware the resident had a discoloration to the left forearm. He further indicated the resident needed assistance with toileting and dressing and the CNAs should have noticed the discoloration and told the nurse.</p> <p>Interview with the DON (Director of Nursing) on 6/9/15 at 4:13 p.m., indicated the resident had a blood draw on 5/26/15 from the left antecubital area. The DON indicated when a discoloration is found an Event would be initiated in the computer and the discoloration would be monitored until the area had healed. She further indicated there was not a</p>			

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R 0000 Bldg. 00	<p>Nursing Note or an Event Report completed of the discoloration and the staff should have observed the discoloration by now and assessed and documented the area.</p> <p>A "Policy and Procedure for Bruises/Skin Tears", received as current from the MDS Coordinator on 6/15/15 indicated "... All staff should observe for bruises/skin tears while conversing with residents. Nursing staff are to check for bruising/skin tears while providing care. (toileting, dressing, feeding etc...)" "...Any bruises/skin tears that are noted are to be reported immediately to the nurse...."</p> <p>3.1-37(a)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 16 Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not	

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of		individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in the requirements of participation or that the corrective action was necessary We are requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946
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(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>the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to invite the local fire department to participate in a fire drill at least every 6 months.</p> <p>Finding includes:</p> <p>The fire drill records were reviewed on 6/15/15 at 10:30 a.m. A signed document indicated the Fire Chief met with facility staff on 5/27/14. There was lack of documentation to indicate the local fire department attended or was invited to a fire drill after 5/27/14.</p> <p>Interviews with the Administrator on 6/15/15 at 12:00 p.m. and 2:15 p.m., indicated she had spoken with the fire chief and he indicated he had been to the facility more recently than May 2014, but the facility was unable to provide any documentation of a visit after 5/27/14.</p>	R 0092	<p>1. Corrective Actions for Residents found to have been affected; No adverse effects have been noted to any residents due to the lack of documentation supporting that the fire department was invited to participate in a disaster/fire drill at least every 6 months.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: No adverse effects have been noted to any residents due to lack of documentation supporting that the fire department was invited to participate in a disaster/fire drill at least every 6 months. Fire department has been invited to attend the fire drill on 6-24-15 and was unable to attend. This was documented on the record.</p> <p>3. Measures put in</p>	06/24/2015

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			<p>place/systemic changes made to ensure it does not happenagain: The Maintenance Director was inserviced on inviting thefire department to participate in a disaster/fire drill at least every 6 months includingdocumentation as to whether or not they attended and having them sign in when theyattend. This inservice occurred on6-16-15. The inspection compliance schedule has been updated to includeinviting the fire dept to participate in a disaster/fire drill every six months.</p> <p>4.How the corrective action will be monitored: Administrator/Designee will audit fire drillrecords monthly for one year to ensure the fire department is invited to attenddrill and that it is documented at least every 6months after one year of 100% compliance,the Administrator/Designee will audit fire drill records quarterly. Audits willbe reviewed in QA monthly for one year then quarterly thereafter until 100%compliance is met. The QA committee will makerecommendations and changes as appropriate.</p>	