STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	2819 N ST JOSEPH AVE EVANSVILLE, IN 47720

(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	This visit was for a Recertification and State Licensure Survey. Survey dates: June 3, 4, 5, 6, 7, 10, and 11, 2013. Facility number: 000239 Provider number: 155348 AIM number: 100290150 Survey team: Amy Wininger, RN, TC Diane Hancock, RN Barb Fowler, RN Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 5 Medicaid: 55 Other: 14 Total: 74 These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2. Quality review was completed on June 17, 2013, Jodi Meyer, RN	F000000	Please accept this Plan of Correction as my credible allegation of compliance. I also respectfully request this Plan of Correction be accepted as paper compliance of the alleged deficiencies. This Plan of Correction is submitted under Federal & State regulations and statutes applicable to LTC providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the suveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments were accurate regarding dental issues for 2 of 3 residents sampled for dental	F000272	1. Immediately, on June 11th, oral assessments were completed by Nursing Administration on residents #91 and #33 and dental referrals were made by SSD. MDS Coordinator	07/07/2013

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	issues, in the sample of 9 who met the criteria. (Residents #91, Resident #33) Findings include: 1. During a family interview on 6/5/13 at 1:09 p.m., Resident #91's family indicated the resident had complained of her gums being sore and they had been using denture adhesive to help. Resident #91's clinical record was reviewed on 6/7/13 at 3:20 p.m. The record included an admission oral assessment, dated 4/5/13. The oral assessment indicated the resident had full dentures, her lips were rough, there was an "inflamed line of demarcation," and the lips were swollen and dry. The mucous membranes were red and inflamed. The gingiva was red. The facility's Initial Data Collection Tool, dated 4/5/13 at 12:30 p.m., indicated the gums hurt on the top and the bottom and were inflamed. The resident's initial Minimum Data Set (MDS) assessment, dated 4/12/13, indicated the resident had no dental issues, no gum inflammation. Interview with the resident, on 6/10/13		will complete modifications on both residents to ensure comprehensive assessments are accurate.2. Oral assessments will be completed on all residents by Nursing Administration by 6/28/13 to ensure accuracy and appropriate referrals will be made. 3. DON will reeducate Licensed Personnel on 07/02/13 regarding throrough completion of oral assessments. ED reeducated Nursing Administration on 6/24/13 regarding section L of MDS. 4. Audits will be conducted weekly by the IDT to verify that oral assessments and the MDS are accurate. The MDS Coordinator or designee following the RAI guidelines will complete modifications. Audit finding will be reviewed by PI Committee monthly for 12 months. PI will determine need for further audits.5. Completion date 7/7/2013.	

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	at 9:55 a.m., indicated she had sore gums; "they grind my food." She indicated she was eating okay. She indicated she had false teeth for 50 years. She was observed to have her dentures in and was not having too much soreness at that time. 2. On 6/4/13 at 7:23 a.m., Resident #33 was observed to be lying in bed with no teeth in her mouth. On 6/5/13 at 10:30 a.m., Resident #33 was observed sitting in her wheelchair in her room with no teeth in her mouth. An observation on 6/7/13 at 2:15 p.m., indicated Resident #33 to be sitting in her wheelchair without her dentures in place. An observation on 6/10/13 at 8:45 a.m., indicated Resident #33 to be sitting up in bed with no dentures in place. During an interview with Resident #33 on 6/4/13 at 7:23 a.m., the resident indicated she had dentures, but did not wear them. Resident #33 indicated the dentures were loose. Resident #33 indicated she did not like to have denture paste applied to			

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	them as she did not like the feel of the paste in her mouth. Resident #33 indicated she did not have a dental appointment scheduled. During an interview with the Case Manager (CM) on 6/10/13 at 10:05 a.m., The CM indicated she was the "back-up" for the MDS (Minimum Data Set) Coordinator. The CM indicated she thought edentulous indicated the resident did not have any teeth or dentures on the MDS assessment. The CM indicated she was unaware the resident had loose dentures. During an interview with the SSD (Social Service Director) on 6/10/13 at 10:30 a.m., she indicated she was unaware the resident was having difficulty with her dentures. The SSD indicated the resident did not have a dental appointment scheduled. Resident #33's record was reviewed on 6/4/13 at 2:35 p.m. Resident #33 had diagnoses including but not limited to, diabetes mellitus type 2, obesity, depression, CHF (congestive heart failure), and anemia, Resident #33's annual MDS assessment, dated 3/7/13, indicated the resident had a BIMS (Brief			

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	Interview for Mental Status) assessment of 15 out of 15, indicating the resident had no cognitive impairment. Resident #33's MDS assessment indicated the resident had no dental problems. Resident #33 oral assessments, dated 12/12/12 and 3/7/13, indicated the resident had dentures. Resident #33's nurses notes, dated 6/2/13 at 7:37 a.m., indicated the 3:00 p.m.-11:00 p.m. nurse had reported the resident had thrown her teeth away. The nurses notes indicated the staff had retrieved the dentures, cleaned them, and returned them to the resident. 3.1-31(a)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview, the facility failed to ensure care plans were developed for the use of psychoactive medications, discharge planning, and urinary incontinence for 3 of 28 residents reviewed for care plans, in the stage 2 sample of 28. (Resident #52, Resident #33, Resident #101) Findings include: 1. Resident #52's clinical record was reviewed on 6/7/13 at 2:28 p.m. The resident was admitted to the facility	F000279	1. Immediately, on 6/10/13, care plans were developed by IDT to address psychoactive meds on resident #52 and #33, discharge planning and urinary incontinence for resident #101.2. Audits will be completed by Nursing Administration by 7/7/13 on residents to ensure care plans were developed for the use of psychotic medications, discharge planning and urinary incontinence. DON reeducated IDT on 06/27/13 on reviewing care plans weekly to ensure appropriate development of care plans.3. DON or designee will reeducate IDT by 07/07/13 on	07/07/2013

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	on 6/13/12 with diagnoses including, but not limited to, chronic obstructive pulmonary disease, muscle weakness, dementia, depression, osteoarthrosis, and dysphagia. The resident's most recent quarterly Minimum Data Set (MDS) assessment, dated 3/30/13, indicated the resident used an antipsychotic medication daily for the past 7 days. The resident had a care plan dated 6/3/13 for crying out/screaming out. The physician's orders included, but were not limited to, Seroquel (antipsychotic medication) 50 milligrams, one tablet by mouth twice a day, ordered originally 10/9/12. The clinical record lacked a care plan for the use of the antipsychotic medication. The lack of care plan was reviewed with the Director of Nurses and the Administrator on 6/10/13 at 3:45 p.m. They indicated there should have been a care plan. 2. Resident #33's record was reviewed on 6/4/13 at 2:35 p.m. Resident #33 had a diagnoses including, but not limited to,		reviewing care plans weekly to ensure appropriate development of care plans.4. Audits will be completed weekly by IDT to ensure appropriate care plans have been developed. Audit findings will be reviewed by PI Committee monthly for 12 months. PI Committee will determilne need for further audits.5. Completion date 07/07/13.	

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	depression, diabetes mellitus type 2, obesity, CHF (congestive heart failure), and HTN (hypertension). Resident #33 had an order, dated 4/12/13, for Klonopin (a medication used for anxiety), an order, dated 4/29/13, for Lexapro (a medication used for depression), an order, dated 3/29/12, for Depakote (a mood stabilizer), and an order, dated 3/29/12, for Cymbalta (a medication used for depression). The annual MDS (Minimum Data Set) assessment, dated 3/7/13, indicated the resident had received antidepressant and antianxiety medications. The care plans lacked any documentation of a plan for psychotropic medications. Interview with SSD (Social Service Director) on 6/10/13 at 10:57 a.m., indicated she was unaware the resident did not have a plan of care for the psychoactive medications. 3. A. Resident #101's record was reviewed on 6/6/13 at 11:00 a.m., Resident #101 had diagnoses, which included, but was not limited to, hyperglycemia, neuropathy, HTN			

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	(hypertension), history of C-difficule (a bowel infection), osteoporosis, and degenerative joint disease. The admission MDS (Minimum Data Set) assessment, dated 3/22/13, indicated the resident to have a BIMS (Brief Interview for Mental Status) assessment of 14 out of 15, indicating a slight mental impairment. The MDS assessment indicated the resident expected to be discharged back to the community. During an interview on 06/07/13 at 10:30 a.m., Resident #101 indicated she intended to return home after receiving therapy services. During an interview on 06/07/13 at 2:00 p.m. the Case Manager (CM) indicated the Resident #101 initially planned to return home after receiving therapy services. The clinical record of Resident #101 lacked any documentation related to discharge planning. The significant change MDS, dated 5/2/13, indicated the resident was frequently incontinent. The MDS indicated the resident had 7 or more episodes of urinary incontinence with a least one episode of continent			

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	voiding. During an interview on 6/7/13 at 2:00 p.m, the CM indicated Resident #101 experienced frequent urinary incontinence. The CM further indicated, at that time, Resident #101 did not have a care plan for urinary incontinence. The clinical record lacked any documentation related to urinary incontinence. 3.1-35(a)			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview, and record review, the facility failed to ensure 1 of 4 residents reviewed for skin conditions, in the sample of 4 who met the criteria, had their care plans revised following changes in physician's orders. (Resident #69) Finding includes: Resident #69's clinical record was reviewed on 6/6/13 at 9:15 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, left tibial fibula fracture, social phobia, dysthymic disorder,	F000280	1. Resident Care Manager immediately revised resident #69's care plan and care plan directive on 06/10/13 to ensure accuracy in plan of care.2. Audits will be conducted on residents' current orders by Licensed Personnel and Nursing Administration by 07/07/13 to ensure revisions of plan of care have been made.3. Licensed Personnel will be reeducated by 07/07/13 by DON or designee regarding physicians' orders. Within 24 hours Mon-Fri, IDT will meet to review and update care plans according to changes in physicians orders.4. Audits will be completed weekly by IDT to ensure care plan revisions have	07/07/2013

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	and peripheral vascular disease. The record indicated the resident had a diabetic foot ulcer, first observed 11/20/12. The resident was hospitalized 5/6/13 with cellulitis of the area. Ankle-brachial index tests done in the hospital on 5/6/13 indicated the resident had moderately severe peripheral vascular disease. The resident had an appointment with a diabetic wound specialist on 6/6/13. He wrote physician's orders as follows: "Keep drsg [dressing] on foot dry and intact, no showers for 1 week Issue Darco shoe {a diabetic, pressure relieving shoe] larger size for left foot Transfers only - no amb [ambulation] on left foot." The physician's progress note from 6/6/13 indicated the following: "Upon debridement of an ulcer on the plantar aspect of the left foot sub [below] 2nd meta [metatarsal] head there is an ulcer 0.9 X 0.7 cm [centimeters] in diameter, 1 cm in depth. Good granulation base..." "No cellulitis at this point or any infection, no erythema, MRSA [Methicillin Resistant Staphylococcus Aureus] is		been made following changes in physicians' orders. Audit findings will be reviewed by PI Committee monthly for 12 months. PI Committee will determine need for further audits.5. Completion date 07/07/13.	

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	not a clinical factor at this time." On 06/10/13 at 8:30 a.m., the resident indicated she knew she wasn't supposed to be walking on her foot; she hesitated to call for help because she was used to being independent. On 6/10/13 10:20 a.m., CNA #1 was interviewed. She indicated resident #69 did everything for herself, that she was told to call if she needed assistance. CNA #1 provided the written care guide CNAs used for instructions for care of the resident. The care guide failed to indicate the resident should not be ambulating on the left foot. The care plan was reviewed at that time. The care plan had not been revised to indicate the resident had orders to transfer only, not to ambulate on the left foot. LPN #1 was interviewed at 10:25 a.m. on 6/10/13. She indicated the resident did most things for herself, but she was not supposed to be bearing much weight on her left foot. She indicated the resident is reminded to call for assistance but will not always do so. Nurses' notes, dated 6/9/13 at 2:37 p.m., indicated the following:			

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	"Alert and oriented X 3 [person, place, time] able to voice wants and needs, requires assist of 1 with adls [activities of daily living], independent with transfers and toileting, ambulates with rolling walker, propels self in wheelchair, feeds self after tray set up..." 3.1-35(d)(2)(B)			

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F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 1 of 8 residents observed during medication pass. 2 medication errors were observed during 26 opportunities for error. This resulted in an error rate of 7.69%. (Resident #93) Findings include: LPN #2 was observed, on 6/7/13 at 12:03 p.m., to administer Bethanechol Cl (Chloride) (a medication used to stimulate gastric motility) and Metoclopramide HCl (Hydrochloride) (a medication used for stomach distress) to Resident #93. Resident #93 was observed to be eating lunch when the medications were administered. Resident #93's record was reviewed on 6/7/13 at 1:00 p.m. Resident #93 had an order, dated 3/28/13, for Bethanechol Cl 25 (twenty-five) mg (milligrams) orally 3 (three) times daily on an empty stomach. Resident #93 also had an order, dated 4/9/13, for	F000332	1. DON immediately reeducated Licensed Personnel on 6/8/13 and 7/2/13 on importance of following physicians' orders for medication administration times. Physician contacted on 6/8/13 to clarify appropriate medicine adminsitration times for resident #93. 2. Audits completed by 07/07/13 by Nursing Administration on residents receiving medications ordered before meals to ensure medications are being administered timely and accurately. 3. DON or designee will reeducate Licensed Personnel by 07/07/13 regarding following physicians'orders related to administering medications before meals.4. Medication pass audits will be completed weekly by Nursing Administration on three residents weekly to ensure before meal medications are being administered timely and accurately. Audit findings will be reviewed by PI Committee for 12 months. PI Committee will determine need for further audits. 5. Completion date 07/07/13.	07/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2013
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	Metoclopramide HCl 5 mg orally 3 times a day before meals. Interview with the DoN (Director of Nursing) on 6/10/13 at 2:00 p.m., indicated the medications should have been given prior to the resident eating any food. The "2010 Nursing Spectrum Drug Handbook" indicated Bethanechol Cl should be given at least 1 hour before or 2 hours after a meal to prevent nausea and vomiting and Metoclorpramide HCl should be given 30 minutes before meals. 3.1-25(b)(1)			

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F000364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to ensure the food served was palatable and at the proper temperature, for 13 of 13 residents who complained of food not served at the proper temperature and for 1 of 1 resident's trays randomly sampled for proper temperature. (Resident #106, Resident #107, Resident #108, Resident #109, Resident #110, Resident #111, Resident #112, Resident #113, Resident #114, Resident #115, Resident #116, Resident #117, Resident #118, Resident #119) Findings include: During the Stage 1 survey the following 13 residents indicated during confidential interviews that food was not served at the proper temperatures. (Resident #106, Resident #107, Resident #108, Resident #109, Resident #110, Resident #111, Resident #112,	F000364	1. Immediately, CDM reviewed serving temperature logs to verify proper temperature. Insulated serving bowls were ordered by CDM in order to maintain proper cold temperatures.2. Audits will be conducted by 07/07/13 by CDM or designee to determine if cold food is served at proper temperature.3. CDM will educate staff by 07/07/13 on using insulated serving bowls for cold items and ice baths for shakes to ensure proper temperature is maintained when serving trays on the halls. 4. Audits will be completed on one tray per unit weekly by CDM or designee to determine proper temperatures of cold food. Audit findings will be reviewed by PI Committee monthly for 12 months. PI Committee will determine need for further audits.5. Complettion date 07/07/13.	07/07/2013

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	Resident #113, Resident #114, Resident #115, Resident #116, Resident #117, Resident #118, Resident #119) The tray service was observed on 06/07/13 to begin at 11:49 a.m. At that time, the first cart of room trays arrived on the Dogwood Unit. The last tray was served at 12:09 p.m. to Resident #28. Temperatures were checked at that time. The chocolate shake measured 60 degrees and the container felt warm to touch. The pudding measured 66 degrees and felt warm to touch. The creamy slaw measured 70 degrees and felt warm to touch. The Policy and Procedure for Food Temperature Control dated 01/01/2007 was provided by the Food Service Manager on 06/10/13 at 10:52 a.m. and indicated, "Food temperatures are maintained during serving times to ensure residents receive safe food served at acceptable temperatures. Guidelines:...cold foods at or below 40 degrees F [Fahrenheit]..." 3.1-21(a)(2)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to ensure the kitchen and kitchen equipment was clean, food was prepared and served under sanitary conditions in that, the inside of the convection oven was soiled, the kitchen floor was soiled, the vent hood over the stove was soiled, and the storage room floor was soiled. This had the potential to affect 74/74 residents who resided in the building. Findings include: The following was observed on 06/03/13 at 10:22 a.m., 06/05/13 at 10:52 a.m. and 06/06/13 at 9:15 a.m.: 1. The inside of the convection oven was observed to be soiled with black debris. During an interview at that time, Cook #1 indicated the debris was spillage. 2. The vent hood over the stove was	F000371	1. CDM reeducated staff on 6/10/13 and 07/02/13 regarding proper cleaning techniques, schedules and documentation. Immediately on 06/07/13, the food vents were cleaned by VIP contractor per previously scheduled maintenance agreement. The convection oven, kitchen floor, and storage room floor were cleaned 06/10/13 by dietary staff.2. A Food and Nutrition Services Dept. Review will be completed by RD on 06/29/13, and any findings will be corrected immediately.3. CDM or designee will conduct audits daily(five times per week) to ensure adherence to cleaning schedule. As Preventive maintenance, the hood vents will be power washed monthly by the Maintenance Dept.4. Audits will be completed daily(five times a week) by CDM or designee to ensure adherence to cleaning schedule. Audit findings will be reviewed by PI Committee monthly for 12 months. PI Committee will determine need for further audits.5. Completion date 07/07/13.	07/07/2013

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	observed to be soiled with black debris and a grease film. During an interview at that time, Cook #1 indicated, the debris was grease and grime. 3. The floor throughout the kitchen was observed to be sticky and have many areas of dried spillage. 4. The floor in the storage room was observed to be soiled with many areas of dried spillage. During an interview on 06/10/13 at 10:20 a.m., the CDM (Certified Dietary Manager) indicated the kitchen and supply room floors should be washed on a daily basis but, were soiled. She further indicated, at that time, the consultant had recommended the vent hood be cleaned more often and she had been thinking about doing that with the help of the maintenance man. A Daily Cleaning Worksheet for May 27-June 10, 2013 provided by the CDM on 06/10/13 at 10:52 a.m. indicated the kitchen floor had last been mopped on 05/30/13. The Weekly Cleaning Worksheets for May/June 2013 provided by the CDM on 06/11/13 at 10:30 a.m. indicated			

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	the convection oven was last cleaned on 05/21/13. A Food and Nutrition Services Department Review dated 04/24/13 and completed by the Registered Dietician indicated the vent hood over the stove was not clean and grease free. The report further included a hand-written note which indicated, "The hoods need cleaned...". 3.1-21(i)(2) 3.1-21(i)(3)			

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	155348		06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	2819 N ST JOSEPH AVE EVANSVILLE, IN 47720

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure ophthalmic drops were dated when opened when completed in 1 of	F000431	1. DON immedicately reeducated Licensed Personnel on 06/10/13 and 07/02/13 on ensuring ophthalmic drops are dated when opened and narcotics are signed	07/07/2013

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	6 medication carts checked for proper labeling and storage of medications and documentation of narcotics. This had the potential to affect 6 residents whose medications were stored on the 300 cart. (Resident #8, Resident #69, Resident #68, Resident #38, Resident # 57, Resident #12) Findings include: An observation was made on 6/10/13 at 11: 55 a.m. of the 300 unit medication cart. The following ophthalmic drops were found to be opened but not dated when they were opened: Resident #8's Artificial Tears Ophthalmic Solution 2 bottles Resident #69's Dorzolamide 2% Ophthalmic Solution Resident #69's Timolol Maleate 0.5% Ophthalmic Solution Resident #68's Artificial Tears Ophthalmic Solution During an interview with LPN #3 on 6/10/13 at 10:30 a.m., she indicated opthalmic drops are to be labeled with the date they are opened. LPN #3 indicated ophthalmic drops are good for 28 days after they are opened. During an interview with LPN #2 on		per policy.2. Audits will be completed on all medication carts and narcotic sheets by Nursing Administration or designee by 07/07/13 to ensure ophthalmic drops are dated when opened and narcotics are signed off appropriately. 3. DON or designee will reeducate Licensed Personnel by 07/07/13 on policy and procedure related to dating ophthalmic drops when opened and policy and procedure related to documentation of narcotics. 4. Audits of medication carts will be completed weekly by Nursing Administration or designee to ensure ophthalmic drops are dated when opened. Narcotic sheets will also be audited weekly to ensure narcotic documentation is timely. Audit findings will be reviewed by PI Committee monthly for 12 months. PI Committee will determine need for further audits.5. Completion date 07/07/13.	

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	6/10/13 at 11:40 a.m., she indicated ophthalmic drops are to be labeled with the date they are opened. LPN #2 indicated ophthalmic drops were to be discarded 30 days after they are opened. An observation was made on 6/10/13 at 11:45 a.m. during a narcotic medication count. The following narcotic medications were not signed for when given by LPN #1 on 6/10/13: Resident #38's Hydrocodone/APAP 7.5-325 mg 1 tablet Resident #57's Hydrocodone/APAP 7.5-325 mg 1 tablet Resident #12's Hydrocodone/APAP 7.5-325 mg 1 tablet Interview with LPN #2 on 6/10/13 at 11:50 a.m., indicated narcotics were to be signed out when they were given. Interview with CM on 6/10/13 at 1:49 p.m., indicated the nurses were to sign out their medications and narcotics when they are given. A policy titled, Controlled Drugs, and obtained from the DoN (Director of Nursing) on 6/10/13 at 3:00 p.m., indicated the narcotic proof of use sheet is accurately maintained on all			

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	resident requiring such medication. The policy indicated the nurse signs off each dose of the controlled drug given by documenting date, hour, resident name, amount dispensed, signature of nurse, and balance after subtracting amount dispensed, A document provided by the Adm (Administrator) on 6/10/13 at 3:15 p.m., titled LTC Facility Pharmacy Services and Procedure Manual, and dated 5/1/10, indicated facility staff should enter the date opened on the label of medications with shortened expiration dates. 3.1-25(m) 3.1-25(d)(2)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure clinical records were complete and accurately documented, for 1 of 1 resident Medication Administration Record observed documented in the stage 2 sample of 28, in that the nurse was observed to fill in gaps in documentation. (Resident #69) Finding includes: Resident #69's clinical record was reviewed on 6/6/13 at 9:15 a.m. The resident's medication included, but was not limited to, Lantus (long acting insulin) 30 units subcutaneously every morning. On 6/6/13 at 1:40 p.m., the	F000514	1. DON immediately reeducated LPN #1 on 06/07/13 and 07/02/13 on timely and accurate documentation of Medication Administration Record.2. Audits will be completed by Nursing Administration or designee by 07/07/13 to ensure timely and accurate documentation of Medication Administration Record.3. DON or designee will reeducate Licensed Personnel by 07/07/13 on timely and accurate documentation of Medication Administration Record and policy and procedure regarding Correction of Medical Record Errors and Omissions. 4. Audits of Medication Administration Record will be completed three times weekly by Nursing Administration or designee to ensure Medication Administration Record is complete. Audit findings will be reviewed by PI	07/07/2013

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	Medication Administration Record (MAR) for Resident #69 was reviewed. The Lantus insulin was scheduled for 9:00 a.m. and had not been documented as given since 6/2/13. LPN #1 approached the medication cart. She indicated the resident had been given her insulin and began documenting the insulin for 6/3, 6/5, and 6/6/13. She indicated she always gave it at the same time she gave the morning dose of Novolog insulin (short acting insulin), so she knew she gave it. She initialed that she had given the insulin and drew a diagram and placed dots to indicate where on the body the injections were given on those dates. The Director of Nurses provided the policy and procedure for "Correction of Medical Record Errors and Omissions," dated 1/18/2008, on 6/11/13 at 10:40 a.m. The procedure included, but was not limited to, the following: "Late entry notes are discouraged because they tend to reduce credibility of the record. However, authorized personnel may make late entry notes in the medical record, which must be done within 48 hours and appropriately labeled as a 'late entry,' dated, and signed..."		Committee monthly for 12 months. PI Committee will determine need for further audits.5. Completion date 07/07/13.	

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	"All additions, corrections, and other changes must be initialed and dated by the person making the entry." 3.1-50(a)(1) 3.1-50(a)(2)			