STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITERIVER BLVD MUNCIE, IN 47303

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F000000	This visit was for the Investigation of Complaints IN00156221 and IN00156738. . Complaint IN00156221 - Substantiated. Federal/State deficiencies related to the allegation are cited at F282 and F514. Complaint IN00156738 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F514. Survey dates: September 22, 23, and 24, 2014 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Surveyor: Betty Retherford RN Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 6 Medicaid: 57 Other: 3 Total: 66	F000000	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Please find attached additional information to support the submitted Plan of correction, including the re-education completed in preparation and implementation of the plan of correction. We are requesting a desk review. Please feel free to contact Jay Myers, HFA, should you need any addtional information to support the desk review at 765-289-3341. Thank You for your consideration.	

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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	Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by Debora Barth, RN.			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a resident who returned from the hospital following treatment for pneumonia received his intravenous antibiotic therapy as ordered by the physician resulting in the need for readmission to the hospital two days later with complaints of chest pain for 1 of 3 residents (Resident #B) reviewed administration of antibiotic therapy and failed to ensure the nursing staff made arrangements for a chest x-ray for 1 of 1 resident reviewed with orders for a chest x-ray in a sample of 4. (Resident #D) Findings: 1. The clinical record for Resident #B	F000282	Resident B was not identified.Resident D was not identified.A one time audit of new admissions or re-admissions has been completed for the past 60 days to ensure medication orders were verified at time of admission and transcribed correctly. In addition, a one time audit has been completed reviewing lab and diagnostic testing orders for the past 90 days has been completed to ensure ordered testing has been completed per MD order. Nursing staff have been re-educated on the admission - re-admission medication transcription process and expectations, obtaining verification of medications with attending physician at the time of	10/16/2014

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	was reviewed on 9/23/14 at 10 a.m. Diagnoses for the resident included, but were not limited to, aortic dissection 2 years ago, paraplegia, chronic kidney disease with dialysis, and history of methicillin resistant staphylococcus aureus. A quarterly Minimum Data Set assessment, dated 7/23/14, indicated the resident had no cognitive impairment. The clinical record indicated the resident complained of chest pain while out on furlough to the dialysis center on 9/3/14. The resident was sent to the emergency room from the dialysis center and admitted for treatment. The resident returned to the facility on 9/6/14. Readmission orders and information on the hospital transfer form, dated 9/6/14, indicated the resident had been treated for healthcare acquired pneumonia and chronic kidney disease. Two of the readmission orders on the transfer form were for the resident to receive Meropenem (an antibiotic) 500 milligrams intravenously (IV) every 8 hours for 7 days and doxycycline (an antibiotic) 100 mg twice daily. The nursing notes lacked any information related to the resident's attending		admission - re-admission, as well as obtaining lab orders as per MD order.It is the responsibility of the Licensed Supervisory Nurse to complete the admission - re-admission process, completing admission, re-admission orders, and to order and obtain labs and diagnostic testing as per MD order. The DON/designee will be responsible to review admission - re-admission residents and lab/diagnostic testing orders 5 times a week for 8 weeks, weekly for 16 weeks, monthly for 3 months, and then quarterly for 2 quarters to ensure Licensed Supervisory Nurses transcribe medication, lab, and diagnostic testing orders as per MD order, and complete said orders. Any further non compliance will result in 1:1 re-education, disciplinary action as determined necessary, up to and including termination. The HFA/designee will be responsible to review the results of auditing of the admission - re-admission process and lab-diagnostic monitoring as per schedule identified. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QAPI Committee.	

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	physician having been contacted for confirmation of the readmission orders The clinical record indicated the doxycycline was given as ordered, but lacked any information related to the IV Meropenem having been initiated as ordered by the transferring hospital physician. On 9/8/14 at 7:15 p.m., the resident complained of chest pain to the staff. He indicated it was "achy and continuous". The resident's physician was contacted and he was transferred to the hospital for evaluation and then admitted for treatment. The resident was readmitted to the facility on 9/9/14 at 1:10 p.m. with the continued diagnoses of pneumonia. The doxycycline and Meropenem were reordered on the 9/9/14 transfer form and were given as ordered. The hospital physician who provided care to the resident while in the hospital for both admissions was interviewed on 9/23/14 at 2:10 p.m. She indicated the medication records and orders sent to the emergency room from the facility on 9/8/14 lacked any information related to the resident having received the IV Meropenem every 8 hours from his 9/6/14 hospital discharge through his return to the hospital on 9/8/14. She			

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	indicated she questioned the resident related to his IV medication when readmitted on 9/8/14 and he indicated he had not received the IV medication between the two hospital stays. The DON and Administrator were interviewed on 9/23/14 at 2:15 p.m. Additional information was requested related to the IV Meropenem medication having not been given from 9/6/14 through 9/8/14 as ordered by the physician. Information was also requested related to the lack of documentation of the staff confirming the 9/6/14 readmission orders with the resident's personal physician upon the resident's return to the facility. The DON was interviewed on 9/24/14 at 9:05 a.m. She indicated the nurse on duty when the resident was readmitted to the facility on 9/6/14 had not reviewed all of the transfer orders fully and the Meropenem order had been missed and not given as ordered. She indicated she had no other information to provide. Review of the current facility policy, revised January 2012, titled "Admission Orders", provided by the Administrator on 9/24/14 at 8:35 a.m., included, but was not limited to, the following:			

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	"Subject... Resident Admitted from Hospital, LTC [long term care] center, ER [emergency room, etc. 1. Review the transfer orders (if from another long-term care center or hospital). 2. Contact the attending Physician as soon as possible upon admission... to confirm orders.... 3. Review the transfer orders with the attending Physician and obtain approval. ...6. Transcribe the approved transfer orders and any further orders onto the Physician's Order Sheet...." 2. The clinical record for Resident #D was reviewed on 9/22/14 at 2:25 p.m. Diagnoses for the resident included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, and diabetes mellitus. A physician's order, dated 9/10/14, indicated the resident was to have a chest x-ray done related to chest congestion and non productive cough.			

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	The clinical record lacked any chest x-ray dated 9/10/14, 9/11/14, or 9/12/14. A physician's order, dated 9/13/14, indicated the resident was to have a chest x-ray taken on that date. A chest x-ray report for Resident #D, dated 9/13/14, indicated "Mild cardiomegaly with mild congestive heart failure." The DON and Administrator were interviewed on 9/23/14 at 2:15 p.m. Additional information was requested related to the lack of a chest x-ray having been completed related to the 9/10/14 order. The DON was interviewed on 9/24/14 at 9:05 a.m. She indicated the nursing staff had failed to make arrangements for the 9/10/14 chest-ray and it was reordered and completed on 9/13/14. This federal tag relates to Complaints IN00156221 and IN00156738. 3.1-35(g)(2)			
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			

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	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 record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 1 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 4. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 9/22/14 at 2:25 p.m. Diagnoses for the resident included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, and diabetes mellitus. The clinical record indicated Resident #D was sent to the emergency room for treatment of edema of the bilateral lower extremities and extensive deep vein thromboses on 8/28/14. The nursing notes lacked any information related to the date and time the resident	F000514	Resident D was not identified.A one time audit of current resident population for the past 30 days was completed to ensure new orders received making an increase or adding a new medication are initiated timely, NP - MD visits are documented in the nurses notes section, and admissions or re-admissions assessments have been completed and documented in the medical record. Licensed Supervisory Nurses have been re-educated on noting orders timely including correct initiation times on the Medication record, documentation of NP-MD visits in the nurses notes, and completing nursing assessments of a resident and documentation of said assessment in the medical record.It is the responsibility of the Licensed Supervisory Nurse to assess residents at time of return from hospital, note NP-MD orders timely, initiate new medication orders. The DON/designee will be responsible to review admission - re-admission assessment of	10/16/2014

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	returned to the facility or any assessment of the resident at the time of her return from the hospital. The Medication Administration Record (MAR) for September 2014 indicated the resident had an order for Lasix (a diuretic) 60 milligrams to be given twice daily at 8:30 a.m. and 8:30 p.m. The MAR indicated this order was discontinued after the morning dose on 9/5/14. A Nurse Practitioner (NP) assessment note, dated 9/4/14, indicated the resident was seen by the NP on that date. A handwritten note indicated the resident's diuretics would be increased and Lasix 80 milligrams would be started twice daily. The nursing notes, dated 9/4/14, lacked any information related to the NP visiting the resident or any medication changes related to the NP visit. A physician's order, dated 9/4/14, indicated "Increase Lasix to 80 milligrams by mouth twice daily." The time the order was given was not noted on the order sheet. A nurse's signature indicated the order had been received at 3:50 a.m.		residents documentation, new medication orders noted and initiated timely, and NP-MD visit documentation 5 times a week for 8 weeks, weekly for 16 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any further non compliance will result in 1:1 re-education, disciplinary action as determined necessary, up to and including termination. The HFA/designee will be responsible to review the results of auditing of the admission - re-admission assessment documentation, NP-MD visit documentation, and initiation of new medication orders as per schedule identified. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QAPI Committee.	

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	The September MAR indicated the medication change was not started until the evening shift on 9/5/14. The DON and Administrator were interviewed on 9/23/14 at 2:15 p.m. Additional information was requested related to the delay in increasing the resident's Lasix Medication ordered on 9/4/14. Additional information was requested related to the lack of documentation of the resident's return from the hospital and any assessment having been completed upon the resident's return to the facility following the 8/28/14 transfer to the emergency room for evaluation. The DON was interviewed on 9/24/14 at 9:05 a.m. She indicated Resident #D's nursing notes were not complete and accurate. She indicated the best she could determine was that the NP had visited late in the evening on 9/4/15 and the order had not been noted and reviewed until 3:50 a.m. on 9/5/14 and then the change began with the evening dose on 9/5/14. She indicated she had no other information to provide. This federal tag relates to Complaints IN00156221 and IN00156738. 3.1-50(a)(1)			

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	3.1-50(a)(2)			