STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155516	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MEMORIAL HOSPITAL-CCC	2200 RANDALLIA DR FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30 and 31, April 1, 4 and 5, 2016 Facility number: 001203 Provider number: 155516 AIM number: N/A Census bed type: SNF: 40 Total: 40 Census payor type: Medicare: 34 Other: 6 Total: 40 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. QR completed on March 6, 2016 by 17934.	F 0000		

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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F 0279 SS=E Bldg. 00	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 interview and record review, the facility failed to develop care plans which addressed the use of Insulin and Eliquis (anticoagulant) for 1 resident (Resident #11) and addressing the use of Coumadin (anticoagulant) for 3 residents (Residents #47, #211, #144) of 5 residents who met the criteria for unnecessary medication. The facility also failed to develop a care plan which addressed the use of a urinary catheter for 1 resident (Resident #226) of 4 residents who met the criteria for urinary catheter use.	F 0279	April 18, 2016 Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID MDYC11 Dear ISDH:	05/01/2016

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	Findings include: 1. Review of the clinical record for Resident #11 on 4/4/16 at 10:34 a.m., indicated the following: diagnoses included, but were not limited to, insulin dependent diabetes mellitus, cerebral infarction (stroke), congestive heart failure, chronic obstructive pulmonary disease, hypertension, and atrial fibrillation. A physician's order for Resident #11, dated 2/15/16, indicated a 2000 Calorie Diabetic Diet with Glucerna TID with meals. The order also indicated to initiate anticoagulant therapy plan per anticoagulant management policy. A physician's order for Resident #11, dated 2/24/16, indicated Eliquis 2.5 mg (milligrams) BID (twice a day). A physician's order for Resident #11, dated 2/25/16, indicated Lantus insulin 35 units HS (hour of sleep). A physician's order for Resident #11, dated 2/26/16, indicated Humalog insulin 4 units TID (three times a day) with meals. Review of facility care plans for Resident		On April 5, 2016, a Recertification and State Licensure survey was conducted at our facility. Please find a POC for that survey attached. Additionally, I would like to request paper compliance for these citations. Thank you for your consideration. Sincerely, Iyvonne Byers, Administrator Parkview Memorial Hospital-CCC 2200 Randallia Drive Fort Wayne, IN 46805 POC map: 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken 3) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur	

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	#11 did not include a care plan for her insulin dependent diabetes mellitus or for the use of the anticoagulant. The Assistant Director of Nursing (ADON) was interviewed on 4/4/16 at 11:52 a.m. During the interview, she indicated there should have been a specific care plan on diabetes and the anticoagulant for Resident #11. 2. Review of the clinical record for Resident #47 on 4/4/16 at 1:36 p.m., indicated the following: diagnoses included, but were not limited to, atrial fibrillation, cerebrovascular accident (stroke), and chronic Coumadin anticoagulation due to chronic atrial fibrillation. A physician's order for Resident #47, dated 3/7/15, indicated to initiate an anticoagulant therapy plan. A Progress Note for Resident #47, dated 3/8/15 and written by the Pharmacist, indicated pharmacy was asked by her physician to dose her Coumadin. A physician's order for Resident #47, dated 3/31/16, indicated Coumadin 3 mg daily with the dose on 4/5/16 held due to an elevated INR level.		4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place 5) By what date the systematic changes will be completed F279-E 1) Care plans were added for Resident #11 (Insulin and Eliquis), Resident(s) #47, #211, #144 (Coumadin), and Resident #226 (catheter). 2) All residents with orders for Insulin, Eliquis, Coumadin, and catheters were reviewed by DON/ADON to ensure presence of care plan. All care plans in place. 3) Care plans will be reviewed by Nurse Lead, Patient Coordinator, or MDS coordinator after completion by admitting nurse to ensure all required care plans are present. 4) DON will select 5 residents admitting in the quarter to review for appropriate care plans. Selection and review will continue until all care plans are present for 2 consecutive quarters. 5) May 1, 2016	

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	Review of facility care plans for Resident #47 did not include a care plan for the use of the anticoagulant. The ADON was interviewed on 4/4/16 at 2:37 p.m. During the interview, she indicated Resident #47 did not have a care plan for the use of the anticoagulant. She also indicated a care plan should have been developed. 3. Review of the clinical record for Resident #211 on 4/4/16 at 3:08 p.m., indicated the following: diagnoses included, but were not limited to, insulin dependent diabetes mellitus, coronary artery disease, and atrial fibrillation. A physician orders for Resident #211, dated 3/28/16, indicated to initiate an anticoagulant therapy plan. A Progress Note for Resident #211, dated 3/30/16 and written by the Pharmacist, indicated the pharmacy was asked by her physician to dose her Coumadin. A physician's order for Resident #211, dated 4/3/16, indicated Coumadin 10 mg daily. Review of the care plans for Resident #211 did not include a care plan for the use of an anticoagulant.			

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	The ADON was interviewed on 4/5/16 at 11:02 a.m. During the interview, she indicated a care plan on the use of the anticoagulant had not been developed for Resident #211. 4. Review of the clinical record for Resident #144 on 4/5/16 at 8:49 a.m., indicated the following: diagnoses included, but were not limited to, chronic systolic congestive heart failure, atrial fibrillation, cardiomyopathy, and congestive heart failure. A physician's order for Resident #144, dated 3/18/16, indicated to initiate an anticoagulant therapy plan. A Progress Note for Resident #144, dated 3/19/16, indicated Pharmacy was asked by her physician to dose her Coumadin. A physician's order for Resident #144, dated 4/4/16, indicated Coumadin 1 mg daily. Review of the care plans for Resident #144 did not include a care plan for the use of an anticoagulant. The ADON was interviewed on 4/5/16 at 11:02 a.m. During the interview, she indicated a care plan on the use of the			

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	anticoagulant had not been developed for Resident #144. She also indicated the admission nurse for a resident was responsible for initiating care plans. 5. Review of the clinical record for Resident #226 on 4/4/16 at 4:00 p.m., indicated the following diagnoses included, but were not limited to, Fournier's gangrene (an acute necrotic infection of the perineum), severe sepsis (a severe blood infection), acute renal failure, hypertension and diabetes. Resident #226 was admitted to the Continuing Care Unit on 3/8/16 from the acute care hospital. An interview with RN (Registered Nurse) #1 on 3/30/16 at 3:32 p.m., indicated Resident #226 had an indwelling Foley catheter due to 2 large open wounds, one on the right groin and the other wound was on the scrotum. She further indicated the catheter was placed to prevent infection and promote healing of the wounds. Review of Resident #226's Admission MDS (Minimum Data Set) Assessment, dated 3/15/16, on 4/4/16 at 4:00 p.m., indicated the Resident had an indwelling Foley catheter and the MDS Assessment also indicated the resident had surgical wounds.			

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	Review of Resident #226's Admission Assessment, on 4/4/16 at 4:05 p.m., indicated, "...Bladder: Indwelling Catheter...." Review of the physician's orders for Resident #226, on 4/5/16 at 9:15 p.m., indicated the following: An order dated 4/4/16, "...Discontinue Foley Catheter...." An order dated 4/4/16, "...Straight cath (catheter) as needed...." An interview with the ADON (Assistant Director of Nursing) on 4/5/16 at 10:30 a.m., indicated Resident #226 was admitted to the Continuing Care Unit with a Foley catheter from the acute care hospital. She indicated the Foley catheter was placed due to the location of resident's wounds. She also indicated the Resident's catheter was currently discontinued. A facility care plan for Resident #226, with a start date of 03/08/16, indicated, "... problem area of Compromised Skin Integrity...." The Goals and Interventions to the problem included, but were not limited to, "... skin integrity is maintained or improved: assess and monitor skin integrity... identify patients at risk for skin breakdown on admission and per policy...collaborate with interdisciplinary team and initiate plans and interventions as needed...keep skin clean, dry and moisturized...."			

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	A facility care plan for Resident #226, with a start date of 03/08/16, indicated, "...problem area of Daily Care...." Goals and Interventions to the problem included, but were not limited to, "...daily care needs are met: Assess and monitor ability to perform self care and identify potential discharge needs...Assess skin integrity/risk...implement skin integrity plan of care and interventions per policy..." Review of the care plans for Resident #226 did not include a care plan for the indwelling Foley catheter. An interview with the ADON on 4/5/16 at 11:00 a.m., indicated Resident #226 did not have care plan to address care of the Foley catheter. She also indicated the Foley catheter care was not an intervention included for the problem of alteration of skin integrity for the resident's wound. She further indicated there should have been a care plan developed for the resident's Foley catheter. Review of the current facility's policy, Assessment and Plan of Care, with a Last Revision Date of 04/1994, provided by the DON (Director of Nursing) on 4/5/16 at 4:09 p.m., indicated, "...A registered nurse coordinates the completion of each resident's assessment. The comprehensive resident assessment/plan of care will be developed to maintain or			

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	improve each resident's mental, psychological and physical well-being. The plan of care: is developed to the extent practicable, in consultation with the resident (or his /her legal representative) and by a[sic] interdisciplinary team coordinated by an RN; is periodically reviewed and revised after each assessment; and describes the medical, nursing and psychosocial needs of the resident and how such needs will be met....The purpose of the assessment is to provide quality care to the residents as determined by their individual needs....the care plan takes into account all the physical, psychological and social characteristics of the resident...." 3.1-35(a) 3.1-35(b)(1)			