

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 01/13/2014
--	---	--	---

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

(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	<p>This visit was for the investigation of Complaint number IN000142314.</p> <p>Complaint number IN000142314 - Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: January 10 and 13, 2014</p> <p>Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100</p> <p>Survey Team: Kim Davis, RN,TC Shelly Reed, RN (January 10, 2014)</p> <p>Census Bed Type: SNF: 4 SNF/NF: 60 Total: 64</p> <p>Census Payor Source: Medicare: 9 Medicaid: 54 Other: 1 Total: 64</p> <p>Sample: 3</p>	F000000	<p>This Plan of Correction consitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report. "We respectfully request that your office will accept this plan as our facility's compliance." Please review our attachments with the one cited defciency as an audit tool. If you have any questions, please contact me at (765)289-3311. Thank you in advance for your immediate attention in this matter.</p>	
---------	---	---------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/13/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303		
(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	
F000323 SS=G	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent the thermostat in the room from being turned on high for 1 of 3 residents reviewed for accidents. This failure resulted in burns requiring hospitalization in a burn unit and skin graft surgery (Resident # B).</p> <p>Findings Include:</p> <p>During the initial tour on 1/10/14 at 2:00 p.m., RN # 3 provided general information on all current residents. Rooms 106, 114, 210, 215, 216, 222, 224, 309 and 311 were carefully inspected with all baseboard heater covers intact. Resident (B)'s room was within a normal temperature range. The</p>	F000323	<p>Parkview Nursing Center respectfully requests and IDR for the deficiency cited F 323 based on the BIM's score referenced in the 2567 was in-correct. The most recent score was the December 2013 MDS and it was 11, not 10 as so referenced. In addition, Parkview Nursing Center does not see that the surveyor took into account other factors rather than "BIM's score itself to the determine if resident "B" was able to make his own choices with regards to choosing the temperature of this room, nor do we believe the thermastat cover not in place was a causative factor related to this event. The surveyor did not take into consideration the clinical status of the resident immediately before the event that caused the injury, or that a catastrophic medical event occurred which resulted a change in cognitive</p>	01/23/2014	

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 01/13/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303		
(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>baseboard heater was cool to touch. No additional rooms appeared overly warm.</p> <p>During an interview on 1/10/14 at 2:53 p.m., LPN #1 indicated she was the nurse on duty who found Resident (B). She indicated during report, she was informed Resident (B) and his roommate both needed a weight to be recorded. She indicated she asked CNA #2 for assistance weighing both residents. She indicated she was pushing her medication cart behind CNA #2 and was at the doorway of Resident (B) when she heard the CNA call his name and he did not respond. She indicated the light was off in his room and the curtain was pulled.</p> <p>LPN #1 then indicated Resident (B) was laying on his right side with his head parallel to the foot of the bed. She placed him on his back to assess him. She indicated his eyes were open but he did not verbally respond. She indicated he was approximately 2" from the heater and she could feel the heat coming from the baseboard heater. She indicated he was incontinent of urine and was partially laying across his bedside table with one foot partially under the bed. She indicated one of</p>		<p>status that was not within the control of the facility. Resident "B" is to return to the center when discharged from the hospital. The care plans will be reviewed and updated to reflect his current status up his return A one time review of current resident rooms has been completed to ensure thermostat covers are in place. Staff have been re-educated on thermostat cover placements. It is the responsibility of Parkview Nursing Center staff to ensure the temperature of rooms are maintained between 71 and 81 degrees. The Maintenance Supervisor/designee will be responsible to assess resident room temperature to ensure temperatures are maintained between 71 and 81 degrees daily for 30 days, weekly for 12 weeks, monthly for 2 months, and quarterly for 2 quarters. Any room identified as needing future assistance for resident comfort and heat adjustment will be reviewed by the interdisciplinary team daily for 30 days, weekly for 23 weeks, and as needed upon identification of need. The Administrator/designee will be responsible to review the reports as completed. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review as they are completed. Any further action will be determined by the QPI committee.</p>		

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 01/13/2014
--	---	--	---

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

(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>his feet had a cord loosely wrapped around it. She indicated the resident did not shake or nod his head while he was on the floor to respond to her questions. She indicated herself and the CNA moved Resident (B) to the bed and removed his clothing for a complete assessment.</p> <p>She indicated Resident (B) has obvious injuries to his face and shoulder. She immediately called 911 and directed others to start the paperwork for transfer to the local hospital. She indicated she took vital signs and a blood glucose level. She indicated his pupillary response was normal.</p> <p>She indicated Resident (B) had a raised hematoma to his right forehead, swelling of right eye, red area to bridge of nose, swollen lip, "small tennis ball" size red open area to the right shoulder, red area approximately 8 cm x 8 cm to the right posterior shoulder, fluid filled blister to his right index finger and a large red area from his elbow to his shoulder that had fluid-filled blisters.</p> <p>She indicated the resident was often up early because he went out to smoke first thing in the morning. She indicated she had not seen the</p>			

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 01/13/2014
--	---	--	---

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

(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>resident since she came to work approximately 6:20 a.m. on 1/9/14.</p> <p>The clinical record of Resident #B was reviewed on 1/13/14 at 9:30 a.m. The record indicated the resident's diagnoses included, but were not limited to, schizophrenia, dementia, and anxiety.</p> <p>The Initial Minimum Data Set (MDS) Assessment, dated 6/12/13, indicated the resident displayed memory loss and no mood assessment was completed.</p> <p>A Quarterly MDS dated, 12/11/13, indicated the resident's BIM score was 10 of 15, which indicated the resident was moderately, cognitively impaired.</p> <p>The care plan, dated 6/14/13 and updated 1/9/14, indicated the resident had a diagnosis of Dementia and was cognitively impaired.</p> <p>The Initial MDS further indicated Resident # B transferred, ambulated in the room and used the toilet independently. The resident required supervision for ambulation in the hallway and assistance with hygiene and bathing.</p>			

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 01/13/2014
--	---	--	---

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

(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>A nurse note, dated 1/9/14 at 6:45 a.m., indicated "...CNA [Certified Nursing Assistant] yelled at to me (writer). Turned on light and had staff go to get help. Resident was laying on R [right] side, under bedside table but over the metal bar, and left foot had power cord wrapped up or looped around L [left] foot. Asked resident, 'Are you okay?' No response. Rolled on back. 2 assist lifted up to bed, resident's clothes wet (shirt, jeans, & socks) & had staff safely remove them...".</p> <p>The following nurse notes indicated 911 was called and the resident was transferred to the hospital emergency room.</p> <p>An Emergency Room nurse, was interviewed on 1/9/14 at 3:45 p.m. The nurse indicated, the resident had been intubated at the Emergency Room then transferred by helicopter to another hospital's burn unit for treatment.</p> <p>A nurse note, dated 1/9/14 at 9:00 a.m., indicated " Reviewed events... felt heat from heater on where resident was lifted up from off floor...".</p>			

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 01/13/2014	
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303			
(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 facility form entitled, "Admission Skin Assessment", dated 1/9/14, included the following findings by the nurse.</p> <p>"1- 7.5 centimeter (cm) by 4.5 cm of red and dried blood on the resident's forehead 2- Nose swollen with 2 cm by 2 cm red intact area on the bridge of nose 3- Mouth swollen and unmeasurable 4-Right eye, red swollen, unmeasurable 5- Right shoulder red with 7 cm by 3.5 cm open area 6- Left arm was red from shoulder to elbow with 10 cm by 1.5 cm fluid filled blister 7- Back of right shoulder had a 8 cm by 8 cm red area with 'skin rolled back' 8- 8 cm by 3 cm red area to right index finger with 1 cm by 1 cm fluid filled blister"</p> <p>The "Pain Data Collection Assessment" dated 1/9/14, rated the resident's pain at 8 out of 10. This assessment was completed using facial grimacing.</p> <p>Resident # B's room was observed again on 1/10/14 at 3:30 p.m. The resident's bed was approximately three feet from the electric</p>						

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 01/13/2014
--	---	--	---

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

(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>baseboard heater. A night stand with two drawers sat between the head of the bed and wall that the large baseboard heater was attached to under a window. The thermostat to control the heater was on the opposite wall by the bathroom door. The bed side table sat across the resident's bed. The thick black power cord for the bed stretched under the bed from the foot of the bed to where it was plugged in on the wall at the head of the bed.</p> <p>The DoN (Director of Nursing) was interviewed in the resident's room on 1/13/14 at 9:45 a.m. The DoN indicated the resident was found by staff on the floor, partially under the bedside table and partially on top of the baseboard heater. The bedside table had reading materials covering the top. The DoN indicated nothing on top of the table had been moved. The baseboard heater was cool to the touch at the time of interview. The DoN indicated Resident # B was a "fiddler". He fiddled with everything and maybe he was fiddling with the power cord on his socks when he fell. The power cord for the bed was at the time long enough to lay on the floor stretching from one end of the bed to the other. The DoN indicated the maintenance</p>			

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 01/13/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303		
(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>man had affixed the cord to the under frame of the bed so it could not be reached by the resident. The DoN further indicated at the time of the fall, the resident was wearing pants, shirt, and socks. The DoN indicated the resident was seen by staff fully dressed at 5:00 a.m. in the hallway, so he probably went back to bed after that.</p> <p>The DoN was again interviewed on 1/13/14 at 1:40 p.m. The DoN indicated her investigation had found that after Resident # B's fall, a CNA found the baseboard heater in the resident's room to be on "high". The CNA turned the thermostat down.</p> <p>CNA # 2 was interviewed on 1/13/14 at 2:10 p.m. The CNA indicated the resident liked to get up early. The CNA indicated when she went into the resident's room on 1/9/14 at 6:45 a.m., the room was warm. The CNA did not look at the thermostat because the resident was often cold. The CNA indicated she found the resident on the floor. The resident's face and arm were on the baseboard heater, and the power cord for the bed was looped around his foot. The CNA indicated she called for the nurse. When she and the nurse rolled the resident, they</p>				

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 01/13/2014
--	---	--	---

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

(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>saw what she thought were burns on the resident's arms and face. The CNA further indicated she worked the facility on all three shifts. The CNA indicated the resident did often get up early in the morning then go back to bed, or some nights, not go to bed at all. She indicated the resident was "cold a lot". She would bring him a jacket or blanket on different occasions. The CNA indicated the resident "liked to fiddle" with things.</p> <p>The DoN was again interviewed on 1/13/14 at 2:15 p.m. The DoN indicated the thermostats in some of the resident room were locked so that only nurses and management staff could access them. The DoN indicated staff would sometimes tell the maintenance man that a thermostat was turned on high in a resident's room and the maintenance man would put the lock on that particular thermostat. She indicated the facility did not have a policy for covering the thermostats. She indicated the thermostat in Resident B's room was not locked. The DoN indicated, thinking back, the resident was a fiddler and the thermostat probably should have had a lock.</p>			

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 01/13/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(1)			