STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PARKVIEW CARE CENTER	2300 PARKVIEW LN ELWOOD, IN 46036

(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 the Investigation of Complaints IN00162073 and IN00162145. Complaint IN00162073 - Substantiated. Federal/State deficiencies related to the allegations are cited at F325 and F514. Complaint IN00162145 - Substantiated. Federal/State deficiencies related to the allegations are cited at F325 and F514. Survey dates: January 14, 15, and 16, 2015 Facility number: 000372 Provider number: 155522 AIM number: 100289060 Surveyor: Betty Retherford RN Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 5 Medicaid: 34 Other: 26 Total: 65	F000000	Community Parkview Care center would like to request paper compliance for F325 ad F514 Any consideration to this request would be greatly appreciated Thank You Glenn Burke-HFA	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155522		01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PARKVIEW CARE CENTER	2300 PARKVIEW LN ELWOOD, IN 46036

(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
	Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by Debora Barth, RN.			
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure a resident, identified as being nutritionally at risk due to a history of poor appetite, diabetes mellitus requiring insulin therapy, and history of weight loss, was monitored for meal replacements when she ate less than 50% of her meal for 1 of 3 residents reviewed for weight loss monitoring in a sample of 3. (Resident #B) Findings include:	F000325	Resident # has passed away since the return of the plan of correction All residents have been determined to be at risk to be affected by this deficient practice An in-service education will be conducted by our Nutrition at risk coordinator or their designee to instruct all staff to ask residents (who consume less than 50 percent of their meals) a replacement, and the proper way to document that replacement. The Nutrition at risk committee will review all replacement	02/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	The clinical record for Resident #B was reviewed on 1/14/15 at 11:30 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, right lower limb amputation, anemia, and history of cerebral vascular accident.. Admission orders, dated 12/31/14, indicated the resident received a regular diet. The orders also indicated the resident received 12 units of Novolog (a fast acting insulin) 3 times daily before meals and Levemir (a long acting insulin) 15 units daily at bedtime. The clinical record indicated the resident was in and out of the hospital on 5 occasions from 10/1/14 thru 1/8/15. The resident had an above the knee amputation during the 12/5/14 thru 1215/14 hospitalization. She was also noted to have a weight loss prior to this hospitalization. She weighed 184.2 on 11/12/14 and 175.4 on 12/5/14 prior to her transfer to the hospital. A health care plan problem, initiated on 11/22/11 and last revised on 1/14/15, indicated Resident #B was at high nutritional risk due to diabetes mellitus requiring insulin, need for wound healing, history of poor appetite, and prevention of significant weight loss.		consumption records and weight fluctuations on a weekly basis. The DON or their designee will complete weekly chart audits for 6 consecutive weeks and review all weight reports and residents with weight change to ensure that changes are identified and appropriate interventions have been put into place. Care plans will be reviewed for updated information to reflect these interventions. Records with weight fluctuations and nutritional concerns will continue to be monitored on an ongoing basis, at our weekly NAR meeting for replacements and consumption of the meals. Audited records will be reviewed by our QA committee, monthly for at least 1 year, until such time consistent compliance has been achieved as determined by the committee. The committee will then monitor quarterly thereafter. The date of compliance for this deficiency is February 15, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	Approaches for this problem included, but were not limited to, "Continue to offer alternatives for any food item refused". Food consumption records for December 1, 2014 through January 13, 2015 lacked documentation of the resident's meal consumption and/or offering of any replacement for uneaten foods (when less than 50% was consumed) on the following dates and times during which the resident was present in the facility: December 2014 1st - Breakfast and lunch 0-25% eaten, supper refused. No replacement information documented. 2nd - Lunch and supper 0-25% eaten. No replacement information documented. 3rd - Lunch 26- 50% eaten. Supper 0-25% eaten. No replacement information documented. 4th - No breakfast or lunch documented. Supper 26-50%. No replacement information documented. Hospital 12/5 to 12/15/15 16th - Supper 26-50% eaten. No replacement information documented.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	17th - Breakfast and lunch 26-50%. Supper 0-25% eaten. No replacement information documented. 18th - Breakfast 26-50% eaten. No lunch information documented. Supper 0-25% eaten. No replacement information documented. 19th - Breakfast 16-50% eaten. Supper 0-25% eaten. No replacement information documented. 20th - Supper 26-50% eaten. No replacement information documented. 21st - Breakfast 26-50% eaten. No replacement information documented. Lunch and supper- no meal documentation information. 22nd - Breakfast and supper. 26-50% eaten. No replacement information documented. 23rd - Breakfast 26-50% eaten. Lunch-refused. Supper 0-25% eaten. No replacement information documented. Hospital 12/24-12/31/14 January 2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	1st - Breakfast refused. Lunch 26-50%. No replacement information documented. Hospital after lunch on 1/1/15 -1/8/15 9th - Lunch refused. No replacement information documented. Supper not documented. 10th - Breakfast 0-25% eaten. Lunch and supper 26-50% eaten. No replacement information documented. 11th - Breakfast refused. Lunch 26-50% eaten. Supper 0-25% eaten. No replacement information documented. 12th - Lunch and supper 0-25% eaten. No replacement information documented. 13th - Lunch and supper 0.25% eaten. No replacement information documented. The Administrator, DON, and Assistant DON were interviewed on 1/15/15 at 9:50 a.m. Additional information was requested related to the lack of meal consumption for some of the dates noted and the lack of replacement meal documentation for the dates noted. The Assistant DON was interviewed on 1/16/15 at 8:30 a.m. She indicated the facility had no information to provide			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	related to the lack of food replacements offered and/or missing meal documentation noted. Review of the current facility policy, dated 9/2010, provided by the Assistant DON on 1/16/15 at 8:45 a.m., titled "Food and Fluid Acceptance Monitoring", included, but was not limited to, the following: "Policy: To record meal and fluid consumption and to record replacements offered. Procedure: 1. After each meal, evaluate the amount of food consumed and document the percentage. 2. If less that 50% was consumed, an alternate food will be offered and percentage consumed will be documented in P.C.C. [point click care computer system] under the task meal replacement consumed...." This federal tag relates to Complaint IN00162073 and IN00162145. 3.1-46(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PARKVIEW CARE CENTER	2300 PARKVIEW LN ELWOOD, IN 46036

(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
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 record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to treatment documentation for 2 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 3. (Resident #B and #C) Findings include: 1. The clinical record for Resident #B was reviewed on 1/14/15 at 11:30 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, right lower limb amputation, anemia, and history of cerebral vascular accident.. The December 2014 treatment record for	F000514	Treatment records for resident #8 and resident # C were reviewed and treatments are being document as ordered All residents receiving wound treatments have the potential to be affected by this deficient practice. The wound treatment records for all residents receiving wound treatments will be reviewed for appropriate documentation. All licensed staff will be educated on proper documentation of treatments provided to residents. The wound care nurse or their designee will monitor documentation of treatments for the facility for 10 records per week for 1 month and 10 records every 2 weeks for 2 months. discrepancies will be promptly reported to the DON. The wound care Nurse will	02/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155522	A. BUILDING 00 B. WING	01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PARKVIEW CARE CENTER	2300 PARKVIEW LN ELWOOD, IN 46036

(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
	Resident #B indicated the resident had an order to "Apply Betadine [an anti-infective] moistened gauze to bilateral heels, cover with ABD [large abdominal size dressing] pad, wrap with Kerlix [a gauze type wrap], secure with tape daily". The treatment record lacked documentation of this treatment having been completed as ordered on December 1, 2, and 4, 2014. The December 2014 treatment record for Resident #B indicated the resident had an order for "Cut Silverfoam [an antimicrobial wound dressing] to fit wounds to right great toe, and toe amputation site on left toe and apply and secure with cover roll 3 times weekly". The treatment record lacked documentation of this treatment having been completed as ordered on December 1, 2014. The Administrator, DON, and Assistant DON (ADON) were interviewed on 1/15/15 at 9:50 a.m. Additional information was requested related to the lack of treatment documentation noted. The ADON was interviewed on 1/16/15 at 9:20 a.m. She provided "24 hour report sheet" information for the dates. The treatments were documented as having been done on the 24 hr report		continue to monitor 10 records per month for 1 year. Findings of the audit will be discussed with the QA team for changes and updates The plan of correction will be monitored at the monthly QA meeting for 1 year and quarterly thereafter. The plan of correction date is February 15th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	sheets. She indicated the 24 hour report sheets were not part of the clinical record and the nurses should have documented the completion of the treatments on the treatment records. 2. The clinical record for Resident #C was reviewed on 1/14/15 at 2 p.m. Diagnoses for the resident included, but were not limited to, enchephlopathy and diabetes mellitus. The January 2015 treatment record for Resident #C indicated the staff were to "cleanse coccyx wound with normal saline, pat dry, apply silvasorb gel to wound and cover wound with 2 inch by 2 inch gauze folded in half and secure with Optifoam adhesive dressing daily and as needed for soilage or displacement." The treatment record lacked documentation of the coccyx treatment having been completed as ordered on January 10 and 11, 2015. The Administrator and DON were interviewed on 1/15/15 at 2:15 p.m. Additional information was requested related to the lack of treatment documentation noted. The Assistant DON was interviewed on 1/16/15 at 9:00 a.m. She provided "24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	hour report sheet" information for the above dates. The treatments were documented as having been done on the 24 hr report sheets. She indicated the 24 hour report sheets were not part of the clinical record and the nurses should have documented the completion of the treatments on the treatment records. 3. Review of the current facility policy, dated 1/09, provided by the Assistant DON on 1/15/15 at 1:30 p.m., titled "Documentation", included, but was not limited to, the following: "Policy All services provided to the resident, or any changes in the resident's condition, shall be recorded in the resident's medical record. Interpretation and Implementation: 1. All observation, medications given, services performed, etc. must be recorded in the resident's chart. 2. The person rendering the services must record entries...." This federal tag relates to Complaint IN00162073 and IN00162145.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036	

(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
	3.1-50(a)(1) 3.1-50(a)(2)			