

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155128	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2013
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NAME OF PROVIDER OR SUPPLIER PARKVIEW OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 411 N WOLF RD COLUMBIA CITY, IN 46725
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: April 30, May 1, 2, 3, 6, 2013.</p> <p>Facility number: 000055 Provider number: 155128 AIM number: 100288410</p> <p>Survey Team: Carol Miller, RN, TC Diane Nilson RN (May 1, 2, 3, 6, 2013) Timothy Long RN (April 30, May 1, 2, 2013) Rick Blain RN</p> <p>Census Bed Type: SNF/NF: 41 SNF: 6 Total: 47</p> <p>Census Payor Type: Medicaid: 27 Medicare: 3 Other: 17 Total: 47</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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.

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	Quality review completed on May 8, 2013 by Randy Fry RN.			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Physician orders were followed for 1 Resident #98, in a sample of 9 residents observed during the medication pass.</p> <p>Findings include:</p> <p>During the medication pass, at 12:25 p.m., on 5/1/13, with LPN #1, Resident #98 was observed to be given Diltiazem 120 milligrams (mg), crushed in water, through the PEG tube (Percutaneous Endoscopic Gastrostomy.) The instructions on the medication packet indicated to give the medication orally 4 times a day. LPN #1 indicated the resident was getting her medications through the PEG tube, and was not getting anything by mouth. The resident was noted to have Glucerna 60 cubic centimeters (cc) per hour infusing through the PEG tube.</p> <p>The resident record was reviewed at 9:50 a.m., on 5/3/13, and physician orders indicated Diltiazem (a blood</p>	F000282	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident affected by this deficient practice had orders reviewed and clarified for route of administration of medications. Care plan for this resident was updated to reflect status of no medications by mouth.</p> <p>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; (All residents have the potential to be affected by the deficient practice.) All residents who are admitted or re-admitted have the potential to be affected. The facility has reviewed all resident charts and found no further similar errors. (See attachment #1)</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The policy on Resident Admissions was revised to include having another licensed nurse verify orders as they are written on the Physician Order Sheet; and any discrepancy on the Medication Reconciliation sheet</p>	05/24/2013

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	<p>pressure medication), 120 milligram tablet, give 1 tablet orally 4 times a day.</p> <p>The Medication Administration Record (MAR) was reviewed at 9:55 a.m., on 5/3/13 and indicated the resident was receiving Diltiazem through the PEG tube 4 times a day.</p> <p>LPN #1 was interviewed at 10:00 a.m., on 5/3/13, and indicated the resident was NPO (nothing by mouth) and was receiving all her medications through the PEG tube as she could not swallow.</p> <p>LPN #1 indicated she had just phoned the Physician to clarify the orders and all the medications were to be given through the Peg tube .</p> <p>Review of the policy for "Resident Admission", provided by the Director of Nursing Services(DNS), at 9:13 a.m., on 5/6/13, and reviewed at 9:30 a.m., on 5/6/13, indicated the following:</p> <p style="padding-left: 40px;">Notify physician of admission and verify all orders by phone.</p> <p style="padding-left: 40px;">Telephone orders form would be used for any subsequent physician orders not obtained at the time of admission.</p> <p style="padding-left: 40px;">Write all orders on the physician's orders sheet.</p> <p style="padding-left: 40px;">Fax a copy of the physician's</p>		<p>needs to be clarified prior to the next medication administration. (see attachment #2). All licensed nurses were in-serviced on the policy change on 5/16/13. Anyone not in attendance will be individually inserviced 5/24/13.</p> <p>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; and</p> <p>An audit will be conducted on all new admissions on the next business day following the admission to assure compliance with the policy. Audits will be conducted on all new admissions and reported at the next quarterly Quality Assurance meeting, then monthly on selected charts. (see attachment #3). After three consecutive reports with 100% compliance, the Quality Assurance committee will assess whether to continue.</p> <p>5. The staff will be in-serviced and audits completed by May 24, 2013.</p>				

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	<p>orders to the pharmacy so that medications were ordered and information gotten into the pharmacy's computer system for monthly rewrites.</p> <p>Place a copy in the chart under the physician's orders tab with medication, dose, route, time, and put in the MAR.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on closed record review and interview, the facility failed to accurately assess a new skin condition, and failed to follow their policy regarding documentation of weekly assessments on the Skin Condition Report and Nursing Notes. This affected 1 Resident #32, in a sample of 3 residents reviewed for pressures ulcers.</p> <p>Findings include:</p> <p>The closed record for Resident #32 was reviewed, at 8:50 a.m., on 5/2/13, and indicated the resident was admitted on 1/3/13 and discharged on 1/31/13.</p> <p>Diagnoses included, but not limited to: Chronic Obstructive Pulmonary Disease, hypertension, weakness, confusion, arthritis, and Diabetes Mellitus.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 1/10/13, indicated the resident did not have</p>	F000309	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident affected by this deficient practice was discharged to home in stable condition in January, 2013.</p> <p>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; (All residents have the potential to be affected by the deficient practice. All residents have the potential to be affected by the deficient practice. Nursing staff will be in-serviced on wound identification and proper documentation. The Pressure Ulcer Prevention and Care policy was reviewed and updated (see attachment #4) and included in the in-service.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurse's were in-serviced on identifying pressure related skin</p>	05/24/2013	

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	<p>any pressure ulcers.</p> <p>The CAA (Care Area Assessment) worksheet, dated 1/10/13, indicated the resident was at risk for pressure ulcers due to impaired mobility.</p> <p>A Nursing Note, dated 1/17/13, indicated Lidex cream was ordered twice a day to an area which was red and excoriated, but did not indicate where to apply the lidex cream.</p> <p>A Physician's order, dated 1/17/13, indicated Lidex cream until healed twice a day, but did not indicate where to apply the Lidex cream.</p> <p>Review of the Medication Administration Record (MAR) for January 2013, indicated Lidex cream twice a day until healed, dated 1/17/13, and in parenthesis "coccyx. "</p> <p>There was no further documentation regarding any skin conditions until a Nursing Note, dated 1/21/13, indicated the resident had an open area to the buttocks, no drainage, light pink in color, and the resident complained of the area being sore and tender. The Nursing Note indicated the Physician was contacted, discontinued the lidex cream, and ordered Nystatin cream twice a day for 5 days.</p>		<p>conditions versus non-pressure related conditions and a post-test was administered to determine understanding (see attachment #5). A weekly audit will be conducted on all wound measurement forms contained in the TAR on the Weekly TAR Wound Audit (see attachment #6). This audit will review whether the initial assessment was done on the correct form and monitor follow up dates to assure weekly re-assessment.</p> <p>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; and</p> <p>The Weekly TAR Wound Audit will be completed weekly by the charge nurse or her designee to review the TAR until the next QA meeting, then monthly for three months or until determined by the QA committee.</p> <p>5. The staff will be in-serviced and audits completed by May 24, 2013</p>	

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	<p>Review of a pressure ulcer assessment form, dated 1/21/13, indicated there was a stage 2 pressure ulcer to the left buttock, which measured 5 centimeters (cm) by 2.2 cm, by 0.1 cm in depth.</p> <p>A second pressure ulcer assessment, dated 1/21/13, indicated there was a stage 2 pressure ulcer to the right buttock which measured 2.5 cm. by 1.0 cm. by 0.1 cm. in depth.</p> <p>A Nursing note, dated 1/22/13, indicated Nystatin cream was applied to the buttock, the area was warm, red, with no drainage.</p> <p>A Nursing note, dated 1/27/13 indicated barrier cream was applied to the bottom and it looked like it was improving.</p> <p>A Nursing note, dated 1/30/13, indicated treatment was applied to the buttock and "looks to be improving."</p> <p>A Situation Background Assessment Request (SBAR), dated 1/28/13, signed by the Physician on 1/28/13, indicated the resident continued to have an area on the bottom, had completed the Nystatin cream, and there was no change noted to the area. The form indicated the resident was being discharged home on 2/1/13, and a request was made for an additional treatment for the</p>			

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	<p>resident.</p> <p>A Physician's Order, dated 1/28/13, indicated Xenaderm was ordered to the bilateral buttocks twice a day until healed.</p> <p>Review of a nurse's weekly summary form, dated 1/31/13, indicated there was an open area to the buttocks with treatment, and review of a form titled "From Parkview Oaks" indicated the resident was to be discharged 1/31/13, and the section under skin condition indicated, "buttocks excoriated with treatment. "</p> <p>There were no further skin assessments or measurements documented after the one completed on 1/21/13 on the pressure ulcer assessment.</p> <p>The Director of Nursing Services (DNS), and RN#2 , the North hall charge nurse, were interviewed on the afternoon of 5/2/13. RN #2 indicated the Lidex cream was ordered on 1/17/13 for a moisture associated area on the buttocks, but was not working, so Nystatin was ordered on 1/21/13 for the same area. She indicated she did not see the area on the buttocks, but another nurse, LPN #3 had reported to her the area was excoriated. The RN</p>			

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	<p>indicated LPN#3 had filled out the pressure ulcer assessment on 1/21/13.</p> <p>RN#2 indicated she monitored the wounds on the North unit, but LPN#3 had not informed her she had filled out the pressure ulcer assessment, so she didn't know about it.</p> <p>The DNS indicated if one of the nurses filled out the pressure ulcer assessment, they would place it in the treatment book and let the charge nurses know in the morning report.</p> <p>The DNS indicated the pressure ulcer areas were to be measured weekly.</p> <p>The DNS indicated RN#2 started monitoring the wound care in February 2013 and prior to this time there was a transition between charge nurses. The DNS indicated this occurred while Resident #32 was in the facility, and was the reason there was no follow up on the pressure area.</p> <p>At 8:05 a.m., on 5/3/13, the DNS indicated the nurse who put the information on the pressure ulcer form, LPN#3 did it in error, and indicated It should have been on a skin condition report for non pressure related areas, as the area was a "moisture associated skin damage" and not a pressure area. She indicated RN#2 had reviewed her</p>			

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	<p>notes from morning report and discovered LPN#3 had put the skin condition assessment on the wrong report and it should have been on the "skin condition report" not the pressure ulcer report. The DNS indicated the skin condition reports are also supposed to be completed weekly and the nurses were responsible to fill out these reports.</p> <p>Review of the policy for "Non-pressure Skin Conditions Treatment Management Protocol" provided by the DNS at 8:05 a.m., on 5/3/13, and reviewed at 8:20 a.m., on 5/3/13, indicated if a new skin condition was noted, the licensed nurse would notify the physician to obtain an order for treatment and complete a Skin Condition Report form and place in the treatment book. The policy also indicated on-going monitoring of the skin condition would be completed daily for the first 24 hours and as needed, and then weekly by the licensed nurse and findings documented in the nurse's notes. Also documentation would be completed on the Skin Condition Report weekly by the licensed nurse.</p> <p>3.1-37(a</p>			

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F000387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure Physician visits were done every 60 days for 1 resident.</p> <p>This deficiency affected 1 of 1 resident in a sample of 17 reviewed for Physician visits (Resident #27).</p> <p>Findings include:</p> <p>The chart on Resident #27 was reviewed on 5/3/13 at 2:00 p.m. The resident's diagnosis included, but were not limited to, chronic cystitis, hypertension (high blood pressure), fibromyalgia, and dementia with mood disorder,</p> <p>The Physician Progress Notes for Resident #27 were dated 1/5/13 and 5/1/13.</p> <p>On 5/6/13 at 8:30 a.m. an interview with the Director Nursing Service (DNS) in regard to the untimeliness of the Physician visits. The DNS</p>	F000387	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The physician saw resident #27 during the survey process.</p> <p>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; (All residents have the potential to be affected by the deficient practice.) All residents have the potential to be affected by the deficient practice. All resident charts were reviewed to see if anyone else was out of compliance. The facility found that no physician is out of compliance per policy.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing checks the resident charts monthly and updates their tracking sheets as necessary (see attachment #7). The facility emails the form or uses the courier per physician</p>	05/24/2013			

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	<p>indicated Resident #27's Physician was notified when the Physician visit for Resident #27 was due.</p> <p>A document provided by the DNS on 5/6/13 at 8:45 a.m. titled the "Physician Visit Tracking Form" dated 2/8/13 indicated Resident #27's Physician was contacted when the next scheduled Physician Visit was due for Resident #27.</p> <p>The policy Physician Visits was received from the DNS on 5/6/13 at 8:45 a.m. was revised on 3/2013 and indicated "...B. Long Term stay residents over 90 days: 1. The resident's Physician of choice will make face-to-face contact with the resident at least every 60 days... C. The Physician ... has a 10 day grace period after the scheduled visit is due to make the visit."</p> <p>On 5/6/13 at 10:15 a.m. the DNS was interviewed and indicated Resident #27's Physician was next notified on 4/10/13 by the Physician Visit Tracking Form. The DNS indicated the next step the facility would had taken was to have the Medical Director see Resident #27. The DNS indicated the facility was in the process of changing Medical Directors.</p>		<p>preference. Per the updated policy (see attachment #8) the Medical Director will see the resident should the primary care physician become delinquent.</p> <p>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; Nursing will audit monthly for physician compliance (see attachment #9). Results will be reported to the Quality Assurance Committee on a quarterly basis. After three consecutive meetings with 100% compliance, either through the primary care physician or Medical Director, the Quality Assurance committee will determine if it is necessary to continue the audits.</p> <p>5. The staff will be in-serviced and audits completed by May 24, 2013</p>				

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(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
	3.1-22(d)(1)			