STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155489	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

(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 a Recertification and State Licensure Survey. Survey dates: June 19, 20, 23, 24, 25, and 26, 2014. Facility number: 000419 Provider number: 155489 Aim number: 100273190 Survey team: Karen Lewis, RN, TC (June 19, 20, 23, 24, and 26, 2014) Tina Smith-Staats, RN Toni Maley, BSW Ginger McNamee, RN Census bed type: SNF: 8 SNF/NF: 66 Residential: 7 Total: 81 Census Payor type: Medicare: 11 Medicaid: 44 Other: 26 Total: 81 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F000000	This Plan of Correction is prepared and executed because it is required by the provisions of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of July 26, 2014. Parker Health Care also respectfully requests paper compliance.	

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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	Quality review completed on June 27, 2014 by Randy Fry RN.			
F000242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents had the right to participate in decision making regarding the number of showers or baths they would desire each week for 5 of 16 residents interviewed regarding bathing choices (Residents #7, #89, #79, #76 and #43). Findings include: During a 6/20/14, 9:59 a.m., interview, Resident #7, who was deemed reliable during the stage 1 survey process, indicated the facility provided residents only 2 showers a week and the resident would desire more "maybe even once a day." During a 6/20/14, 9:39 a.m., interview,	F000242	1. Immediate actions taken for those residents identified: DON completed interviews with those residents affected, to determine their desired frequency of showers per week and their plan of care has been updated as necessary.2. How the facility identified other residents: DON/designee to perform a 100% audit of all residents to determine their desired frequency of showers per week and thier plan of care to be updated as necessary.3. Measures put into place/System changes: An in-service to be presented to staff on the Choices for Resident Care form. The new choices for Resident Care form is to be completed for all current residents and for any future new admits. Resident's choices will be reviewed during care plan	07/26/2014

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	Resident #89, who was deemed reliable during the stage 1 survey process, indicated the facility offered only 2 showers a week and she would truly like more showers. "When I was at home I showered every day." During a 6/20/14, 9:16 a.m., interview, Resident #79, who was deemed reliable during the stage 1 survey process, indicated the facility did not allow the resident to choose the number of showers they desired and they assigned residents 2 showers a week. During a 6/19/14, 11:35 p.m., interview, Resident #76, who was deemed reliable during the stage 1 survey process, indicated she was not asked how often she would like a shower. She was offered 2 showers a week, with no choice offered. At home she "had showered everyday." Resident #43 was determined to be interviewable during the stage one survey process. During a 6/20/14, 9:58 a.m., interview Resident #43 indicated the facility offered only 2 showers a week. Resident #43 stated: "They just tell me how many I get, Tuesdays and Fridays." The 6/23/14, "CNA Assignment Sheets", which were provided by the Director of		meetings by the SSD/designee to ensure the resident is receiving their desired frequency of showers per week. Results of the questionnaires are to be forwarded to the DON to review for any necessary changes. An audit will be completed by the DON/designee following care plan meetings weekly for 2 weeks, then monthly to ensure choices have been reviewed and addressed. Aide assignment sheets and care plans to be updated as needed.4. How the corrective actions will be monitored: Results of the audits will be forwarded to QA monthly for review x's 3 months, then quarterly for a total of 6 months.5. Date of compliance: July 26, 2014	

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	Nursing on 6/23/14 at 8:30 a.m., indicated only 1 of 74 residents received showers more than 2 times a week. The current, undated, "Person Centered Care Admission Questions" document, which was completed for Residents #7, #89, #79, #76 and #43 upon admission and maintained by the Director of Nursing, indicated the following: "We provide showers twice a week....." 7. During a 6/23/14, 1:40 p.m., interview, CNA #4 indicated residents received showers/baths 2 times a week. During a 6/23/14, 1:40 p.m., interview, CNA #1 indicated residents had a shower/bath 2 times a week. She additionally indicated there was one resident who got 3 showers a week. During a 6/23/14, 1:45 p.m., interview, CNA #5 indicated residents were showered/bathed 2 times a week. 3.1-3(u)(1)			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, interview and observation, the facility failed to ensure a health care plan related to fall prevention was reviewed and updated for 1 of 3 residents reviewed for accidents out of a	F000280	1. Immediate actions taken for those residents identified: Resident #34's order for alarms was immediately discontinued. Resident #34's care plan was reviewed for appropriate	07/26/2014

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	sample of 6 who met the criteria for accidents. (Resident #34) Findings include: Resident #34's clinical record was reviewed on 6/23/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, chronic venous embolism and thrombosis of deep vessels of lower extremity, atrial fibrillation, hypothyroidism, esophageal reflux, urinary incontinence, osteoarthritis, depressive disorder, insomnia, and constipation. The resident had an active order for a chair and bed alarm dated 5/31/2014. Review of the care plans indicated resident #34 had a care plan for falls that included the following: "Focus: I have the potential for falls related to receiving narcotic pain patch, anti-depressant, require extensive assistance of staff and walker with toileting, transfers and walking, incontinent of bowel and bladder. Date initiated: 4/28/2014. Revision on 6/21/2014. Goals: I will use walker and wait for assistance of staff to walk and transfers to assist with preventing falls. Interventions: ... Chair pad alarm		interventions and revised.2. How the facility identified other residents: DON/designee to perform a 100% audit of all fall care plans to ensure interventions are appropriate and revise them as necessary. DON/designee to complete a facility sweep and alarm audit to ensure all alarms are placed specifically per physician order.3. Measures put into place/System changes: An in-service to be presented to nursing staff on updating fall care plans. DON/designee to complete an audit of all progress notes and physician orders in clinical meeting to ensure fall interventions are updated as necessary. DON/designee to review fall care plans following each fall and quarterly to ensure appropriate interventions are in place. 4. How the corrective actions will be monitored: Results of the audits will be forwarded to QA monthly for review x's 3 months, then quarterly for a total of 6 months. 5. Date of compliance: July 26, 2014.	

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	Personal alarm on in bed/chair as ordered". Review of the care plans indicated Resident #34 had a care plan for falls that included the following: "Focus: I require assist to ambulate due to diagnosis of Difficulty walking, Altered Mental Status and Debility. Date initiated: 2/19/2014. Revision on : 4/28/2014.... Goals: I will walk 150 feet daily with walker and assist on [sic] one through review date. Interventions: I will be observed for decline in my walking skills and nurse will notify nurse/therapy/physician. I will be allowed to choose time to walk within reason-encourage me to pace self to prevent shortness of breath and/or fatigue. Encourage her to concentrate on walking to prevent her from becoming unbalanced." During an interview on 6/24/14 at 1:30 p.m., Medical Records LPN, she indicated Resident #34 was on a walking program. The walking program consisted of walking one hundred fifty feet daily with assist of one staff daily. She indicated all other ambulation was to be supervised. MDS indicated the resident should not be ambulating without assistance or supervision.			

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	During an interview with CNA #1 on 6/24/14 at 1:37 p.m., CNA #1 was asked if Resident #34 was suppose to have alarms on the chair and the bed. CNA #1 indicated Resident #34 was to have alarms on the bed and the chair, but then CNA #1 looked at her assignment sheet and stated the alarms had been taken away because Resident #34 wanted to get in and out of bed on her own. No alarms were present on the bed or on the chair. During an interview on 6/24/14 at 2:01 p.m., the Director of Nursing provided progress note dated 6/16/14. The progress note indicated Resident #34 had not wanted the alarms because they were too noisy. The Director of Nursing indicated neither the care plan nor the orders had been updated to reflect the change. During an observation on 6/23/14 at 9:00 a.m., Resident #34 was observed walking behind a wheelchair. No assistance or supervision was observed at that time. No alarm was observed on the wheelchair. During an observation on 6/24/14 at 8:55 a.m., Resident #34 was observed in bed with half side rails up on both sides, and			

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	the floor pads were on the floor at the bedside. No alarm box was observed but the connection cord was visible. The wheelchair at the bedside had no alarm present. During an observation on 6/24/14 at 1:37 p.m., Resident #34 was observed in the bed. No alarms were present on the bed or the wheelchair. 3.1-35(d)(2)(B)			
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Bases on observation and interview, the facility failed to ensure it was free from a medication error rate of less than 5%	F000332	1. Immediate actions taken for those residents identified: Physicians for residents #7 and #26 were notified. 2. How the	07/26/2014

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	during the medication administration task. Two errors in receiving medications were observed during 31 opportunities for error in medication administration. This resulted in a medication error rate of 6%. (Resident #7 and #26) Findings include: 1. During a medication administration observation on 6/19/14 at 11:26 a.m., Resident #7 was given a subcutaneous injection of 25 units of Novolog (a rapid acting insulin) by LPN #2. Resident #7 was then seated in the South dining room and served lunch at 12:08 p.m., 42 minutes after receiving the insulin injection. Manufacturer's directions on the patient information insert included, but were not limited to, Novolog should be injected immediately (within 5-10 minutes) before a meal. 2. During a medication administration observation on 6/24/14 at 7:55 a.m., Resident #26 was given a subcutaneous injection of 5 units of Novolog by LPN #3. Resident #26 was then seated in the North dining room and served breakfast at 8:09 a.m., 14 minutes after receiving the insulin injection.		facility identified other residents: All residents whom receive short acting insulin have the potential to be affected. 3. Measures put into place/System changes: An in-service was provided to nursing staff on protocol for insulin administration. A substantial snack will be offered to residents receiving short acting insulin if the meal will not follow within 5-10 minutes of the insulin administration. DON/designee to perform medication pass audit to ensure snacks are provided as necessary 5x/week for 2 weeks, then monthly. 4. How the corrective actions will be monitored: Results of the audits will be forwarded to QA monthly for review x's 3 months, then quarterly for a total of 6 months. 5. Date of compliance: July 26, 2014.	

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	Manufacturer's directions on the patient information insert included, but were not limited to, Novolog should be injected immediately (within 5-10 minutes) before a meal. 3. During an interview with the Dietary Supervisor on 6/24/14 at 3:30 p.m., she indicated breakfast was served daily at 7:55 a.m., in the South dining room and at 8:00 a.m., in the North dining room. She further indicated lunch was served daily at 11:55 a.m., in the South dining room and at noon in the North dining room. 4. During an interview with the RN consultant on 6/24/14 at 3:41 p.m., she indicated the staff are to following the directions on the patient information insert for all insulin administration. 5. Two errors divided by thirty-one opportunities for error times 100 resulted in a medication error rate of 6%. 3.1-25(b)(9)			
R000000	This visit was for a State Licensure	R000000	This Plan of Correction is	

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	Survey. Survey dates: June 19, 20, 23, 24, 25, and 26, 2014. Facility number: 000419 Provider number: 155489 Aim number: 100273190 Survey team: Karen Lewis, RN, TC (June 19, 20, 23, 24, and 26, 2014) Tina Smith-Staats, RN Toni Maley, BSW Ginger McNamee, RN Census bed type: SNF: 8 SNF/NF: 66 Residential: 7 Total: 81 Census Payor type: Medicare: 11 Medicaid: 44 Other: 26 Total: 81 Sample: 7 Parker Health Care and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.		prepared and executed because it is required by the provisions of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of July 26, 2014. Parker Health Care also respectfully requests paper compliance.	

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