

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Dates of Survey: July 15,16, 17, 18, and 21, 2014</p> <p>Facility number: 000372 Provider number: 155522 AIM number: 100289060</p> <p>Survey team: Angela Selleck, RN, TC Kim Davis, RN Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 75 Total : 75</p> <p>Census payor type: Medicare: 12 Medicaid: 42 Other: 21 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 -3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Care Center that the allegations contained in this survey report are accurate or reflect accurately the provision of care and services to the residents at Community Parkview Care Center. The facility requests the following plan of correction be considered its allegation of compliance.	

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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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			
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	<p>Based on record review and interview, the facility failed to ensure the physician was contacted when there was a large weight gain noted for 1 of 32 residents reviewed for physician notification in a sample of 32. (Resident 41)</p> <p>Findings include:</p> <p>The closed clinical record for Resident (41) was reviewed on 7/16/14 at 1:59 p.m.</p> <p>Diagnoses for Resident (41) included, but were not limited to, leukocytosis, anxiety, pleural effusion, congestive heart failure, and hypotension.</p> <p>During record review, Resident (41) was admitted to the facility on 3/27/14 following a hospital stay. A current physician order indicated daily weights to be obtained related to congestive heart failure. The initial admission weight was 123.6 lbs.</p> <p>During review of the March and April, 2014 Treatment Administration Record (TAR), daily weights were obtained. The documented weight on 3/31/14 was 125.3 lbs. The documented weight on April 1, 2014 was 150.6 lbs. The respiratory assessments indicated no change in oxygen saturation or oxygen demand.</p>	F000157	<p>The plan of correction for F-157 will be to notify the physician of the weight gain for resident #41. All resident weights will be reviewed at our weekly NAR meeting by August 19th to help ensure that if there are any large weight gains or losses and the physician will be notified. All resident ordered weights will be monitored every day for 30 days, 3 times a week for the next month and at our weekly Nutrition at risk meeting thereafter. Documentation of the weights will be kept and a checklist that the physician was notified will be kept and given to the administrator for review and verification. The Director of Nursing or their designee will be responsible for providing documentation and providing results at our quarterly QA meeting to help determine if any changes or updates need to be made. This deficiency will be corrected by August the 20th 2014.</p>	08/20/2014			

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	<p>A chest x-ray was obtained on 4/2/14. The x-ray indicated right basilar airspace and large right pleural effusion likely related to pneumonia.</p> <p>Review of a current care plan, dated 4/3/14, indicated Resident (41) also had a problem related to pneumonia requiring antibiotic treatment. One of the approaches to the problem included, but was not limited to, "monitor/document for changes in mental status, stupor and s/s of congestive heart failure and oxygen therapy as ordered."</p> <p>During an interview on 7/18/14 at 11:20 a.m., the Assistant Director of Nursing (ADoN) indicated she could not find any documentation the Physician was notified of the weight gain. She indicated the Physician did see the resident on 4/1/14, but did not document anything related to weight gain.</p> <p>Review of a current undated facility policy, titled "NOTIFICATONS-RESIDENT STATUS", which was provided by the ADoN on 7/21/14 at 9:00 a.m., indicated the following:</p> <p>"Policy: It is the policy of CPVCC to promptly notify physician, resident, resident sponsor of changes in resident</p>			

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F000242 SS=D	<p>status.</p> <p>Procedure: ...b. Significant alteration/change in the resident's plan of care/condition."</p> <p>3.1-5(a)(1)</p> <p>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 observation, interview, and record review, the facility failed to ensure the wake time for 1 of 21 residents reviewed for resident preferences was honored (Resident #66).</p> <p>Findings Include:</p> <p>During an interview with Resident #66 on 7/16/14 at 8:30 a.m., the resident indicated she did not choose her own wake up time. The resident indicated, if she wanted a hot breakfast, she had to get up when her tray was brought into the room. The resident indicated she wanted to wake at 9:00 a.m. and have breakfast after.</p>	F000242	F-242 Since resident # 66 has discharged from the facility all residents preferences will be updated by the 20th of August and transferred to a new preference sheet to be included with the CNA assignment sheet. The Activity director or their designee will be responsible for updating preference sheets and completing and documenting within 24 hours of admission. All residents preference sheets will be updated in conjunction with their MDS schedule or upon request from a resident or family member. The facility will post a memo reminding residents and families of the ability to request a change in preferences and who to notify if you wish to change. The	08/20/2014	

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	<p>The Social Service Director (SSD) was interviewed on 7/18/14 at 10:00 a.m. During the interview the SSD indicated the resident preferences are documented during a pre admission screen and updated with care plan review.</p> <p>The CNA Assignment sheets were provided by LPN #1 on 7/18/14 at 10:00 a.m. The document made no mention of when Resident #66 preferred to be awakened and eat breakfast.</p> <p>CNA #3 was interviewed on 7/18/14 at 10:05 a.m. During the interview, the CNA indicated the Resident Preferences Forms were kept in a binder at the nurse station. The CNA indicated breakfast is at 7:30 a.m. The CNA indicated Resident #66 was served. The CNA indicated Resident #66 stayed in bed until her breakfast tray was served. The CNA further indicated a resident could sleep in and the breakfast tray could be warmed up or a cold cereal could be served.</p> <p>CNA #3 obtained a blank Resident Preference Sheet and interviewed Resident #66. The new preferences were documented as Resident #66 preferred to get up at 9:00 a.m. CNA #3 put the completed document in the binder at the</p>		Activity director or their designee will be responsible for providing completed and updated preference sheets to be included at our quarterly QA for any changes or updates needed with the program. All activity and Nursing staff will be in-serviced to help ensure that this program is effective and communicated.	

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F000247 SS=D	<p>nurse station.</p> <p>On 7/21/14 at 8:25 a.m., Resident #66 was observed in the room in the wheelchair eating breakfast. During an interview on 7/21/14 at 8:25 a.m., the resident indicated there had been no change in her morning schedule over the weekend. The resident indicated, her breakfast was brought in early the last three mornings.</p> <p>During a meeting with the facility management staff on 7/21/14 at 4:00 p.m., further information was requested regarding the lack of choices for Resident #66. No further information was provided.</p> <p>3.1-3(u)(3)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to notify residents of a room transfer for 1 of 21 residents interviewed for admission, transfer or</p>	F000247	F-247The plan of correction for this deficiency will be to document and notify the family of resident #90 being moved to another room because room-mate was actively	08/20/2014

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	<p>discharge. (Resident #90)</p> <p>Findings include:</p> <p>The clinical record for Resident #90 was reviewed on 7/17/14 at 1:20 p.m. Current diagnoses included, but were not limited to, congestive heart failure, anxiety, debility, malaise and fatigue, loss of weight, transient cerebral ischemia, urinary frequency, generalized pain, rhabdomyolysis, head injury, cardiac dysrhythmias and generalized muscle weakness.</p> <p>A review of the Minimum Data Set (MDS) quarterly review assessment, dated 4/11/14, indicated Resident #90 was cognitively impaired.</p> <p>A review of Resident #90's clinical record indicated no documentation or notification of the room transfer.</p> <p>During a family interview with Resident #90's daughter on 7/16/14 at 1:25 p.m., she indicated her mother was transferred to another room due to her roommate was passing away. The daughter indicated she was not notified of the room transfer. The daughter indicated she was the resident's Power of Attorney.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 7/17/14</p>		<p>dying. The facility will update its form in Point Click Care to reflect all of the information required of a room-mate change. 1. Document the reason the resident requires a room-mate change. 2. Inform the current and new room-mate of the change prior to transfer. 3. Provide a 2 day notice of the change unless waived. 4. Notify the Family or responsible party. The social service director or their designee will be responsible for auditing all room changes and ensuring the proper notification and documentation is present. A list verifying all room changes will be given to the administrator for proper documentation and notification validity. This will be done for every room change that happens in the building. The results of the audits will be taken to our quarterly QA for changes and updates needed depending on the results. All Nursing staff will be inserviced on our room-mate policy by the 20th of August to ensure compliance with this deficiency</p>				

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	<p>at 1:00 p.m., she indicated Resident #90 was transferred to another room between the 2-10 p.m. shift for a few hours on 5/16/14 while her roommate was passing and the roommate had passed on 5/17/14 at approximately 12:45 a.m. The ADON further indicated the facility staff should have called the resident's daughter, who is the resident's Power of Attorney, for notification of the room transfer prior to the move to another room and documented the transfer but the facility staff did not.</p> <p>A review of the undated policy titled "Room/Intrafacility" provided by the ADON on 7/17/14 at 3:30 p.m. indicated the following:</p> <p>"Purpose:</p> <p>To provide the least disruptive room transfer of a resident within the facility.</p> <p>Policy:</p> <p>The facility will accommodate the resident's needs regarding room transfer in a manner that would be in the best interest of the resident and will be done in a way to minimize anxiety and provide continuity of care.</p> <p>...Involuntary Room Change:</p>			

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F000248 SS=E	<p>Ensure all reasonable options are explored and alternatives exhausted before taking steps toward involuntary room/intrafacility change.</p> <ol style="list-style-type: none"> Document the reason that the resident requires a room change <ol style="list-style-type: none"> Change in medical condition as judged by the attending physician The room change is necessary for the welfare of the resident or other person. Complete template in PointClick Care titled "Room/Roommate Change" Inform each new and current roommate and his/her family prior to transfer. Staff must provide at least two day notification to the resident and/or legal representative may waive the two-day notification time, unless the welfare of the resident or peer is in question." <p>The ADON indicated she was unable to provide any additional documentation upon exit.</p> <p>3.1-3(v)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in</p>			
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	<p>accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide an activity program for 5 of 5 cognitively impaired residents reviewed for activities. (Residents #76, #18,#2, #1, and #52)</p> <p>Findings Include:</p> <p>1. During the Initial Tour on 7/15/14 at 9:15 a.m., Resident #76 was observed laying on his back in a bed with an air mattress.</p> <p>The resident was again observed in the bed on his back on 7/15/14 at 10:00 a.m., 11:15 a.m., 12:45 p.m., 2:00 p.m., 3:00 p.m., and 4:00 p.m.</p> <p>Resident #76 was observed in bed, on his back on 7/16/14 at 8:30 a.m., 9:30 a.m., 10:30 a.m., 12:30 p.m., 1:00 p.m., 2:30 p.m., and 3:00 p.m.</p> <p>Resident #76 was observed on his back, in bed on 7/17/14 at 8:30 a.m., 10:00 a.m., 11:00 a.m., 12:45 p.m., 1:00 p.m., and 2:00 p.m.</p> <p>Resident #76 was observed on his back in bed on 7/18/14 at 8:30 a.m., 10:30 a.m.,</p>	F000248	F-#248The Plan of correction for this deficiency is to provide an individualized activity program for residents #76,18,2,1,52. This new program will focus specifically on our residents who are cognitively impaired.The Activity director and their assistants will be responsible for providing and documenting activities attended by the residents.A program to meet the interests of the residents will be provided.The Activity staff will interview the residents/families to obtain preferences of activities. Those activities will be dependent on the residents physical and mental ability to attend and participate in the activity being offered. The time spent with each resident will depend on their ability to tolerate as witnessed and documented by the activity staff.The Activity staff will provide a cart with different activities included to meet the needs and wants of the residents requiring one on ones.If the resident is able and would like to attend a group activity the activity will be offered. Resdient/Family preference for activities will be honored.The documented activity sheets will be given to the Administrator to verify time and activity done with the resident. The results of the information will be provided at our quarterly QA	08/20/2014

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	<p>11:30 a.m., 2:15 p.m., and 3:00 p.m.</p> <p>On 7/21/14 at 9:00 a.m. and 2:00 p.m. on his back, in bed. The resident was calling out "hello, hello."</p> <p>The clinical record of Resident #76 was reviewed on 7/18/14 at 11:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, depressive disorder, anxiety state, esophageal reflux, pressure ulcers, and heart disease.</p> <p>Physician orders signed on 6/30/14 included: "may participate in activities as tolerated, bedrest, and hospice."</p> <p>The care plan, dated 6/26/14, indicated, "(Resident's name) is on Hospice services and unable to activity's [sic] at this time". The care plan interventions included: "establish and record the resident's prior level of activity involvement, explain to the resident the importance of social interactions, provide 1:1 visits, and remind the resident that he is free to leave activities at any time and not required to stay for the entire activity."</p> <p>The Nurse Department Scheduler was interviewed on 7/21/14 at 9:05 a.m. During the interview, the Scheduler indicated the resident did call out. She</p>		<p>for updates and changes if needed. All activity staff will be in-serviced by the 20th of August on the newly updated program. All preferences will be updated along with the MDS schedule and included with the one on one activity list along with any preference change from the resident or family. The facility will include all preferences and documentation of activities being provided at our quarterly QA meeting for updates and changes as necessary.</p>				

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	<p>indicated if staff went and talked with him and asked what he wanted, he would stop calling out.</p> <p>The Activity Director (AD) was interviewed on 7/21/14 at 10:25 a.m. During the interview, the AD indicated the facility provided two activities daily for the residents. The AD indicated on Thursdays, they offered three activities. The AD indicated the facility did not have a program for the 33 of 75 demented residents. The AD indicated residents either attended the two daily activities or received one to one room visits from one of the five activity department staff.</p> <p>Activity Aide #13 was interviewed on 7/21/14 at 3:05 p.m. During the interview, the Activity Aide indicated Resident #76 was usually asleep when she went in to do one on one visits with him. She indicated for social stimulation, she read the resident poetry and/or rubbed his arm.</p> <p>2. During the Initial Tour on 7/15/14 at 9:15 a.m., Resident #18 was observed in bed. The resident was again observed in bed from 2:00 p.m. until 4:00 p.m. on 7/15/14.</p> <p>On 7/16/14, Resident #18 was observed</p>			

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>in bed at 8:30 a.m., and 9:30 a.m. From 10:30 a.m. until 11:00 a.m., the resident was in his sitting in his wheelchair in his room. Resident #18 was again in bed at 1:00 p.m. until 2:30 p.m.</p> <p>On 7/17/14, Resident #18 was observed in bed at 8:30 a.m., 10:00 a.m., 1:00 p.m., and 2:00 p.m.</p> <p>On 7/18/14 Resident #18 was observed in bed at 8:30 a.m., 9:30 a.m., 10:30 a.m., and 2:15 p.m.</p> <p>The July Activity Participation Calendar for Resident #18 was presented by the Activity Director on 7/21/14 at 10:20 a.m. The calendar log indicated Resident #18 did not attend an activity in July.</p> <p>The Activity Director (AD) was interviewed on 7/21/14 at 10:25 a.m. During the interview, the AD indicated the facility provided two activities daily for the residents. The AD indicated on Thursdays, they offered three activities. The AD indicated the facility did not have a program for 33 of 75 demented residents. The AD indicated residents either attended the two daily activities or received one to one room visits from one of the five activity staff.</p> <p>The clinical record of Resident #18 was</p>			

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>reviewed on 7/17/14 at 1:45 p.m.. The record indicated the resident's diagnoses included, but were not limited to, Alzheimer's Dementia, Mitral valve replacement, Arteriosclerosis.</p> <p>The Care Plan, dated 6/19/14, indicated Resident #18 was dependent on staff for activities and cognitive stimulation and enjoyed music and nascar racing. The care plan goal indicated one to one visits. The care plan interventions included, 1 to 1 visits and activities if resident unable to attend out of room activities.</p> <p>3. During the Initial Tour on 7/16/14 at 9:15 a.m., Resident # 2 was observed sitting in her room in her wheelchair.</p> <p>Resident #2 was observed on 7/16/14 in her room again at 10:00 a.m. and 3:00 p.m. At 2:00 p.m., on 7/16/14, Resident #2 was observed in an activity. An activity aide was reading to the nine residents present. Resident #2 was sleeping.</p> <p>Resident #2 was observed at "Move and Groove" on 7/17/14 at 2:00 p.m., and on 7/18/14 at 10:00 a.m. The resident did not participate.</p> <p>The clinical record of Resident #2 was reviewed on 7/21/14 at 11:10 a.m. The</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>record indicated the resident's diagnoses included, but were not limited to, senile dementia, memory loss, and depression.</p> <p>The Quarterly Minimum Data Set Assessment, dated 3/7/14, indicated the resident was cognitively impaired.</p> <p>The care plan, dated 6/19/14, indicated Resident #2 needed assistance to activities. The care plan interventions included, "... Assure that the activities the resident is attending are compatible with the resident's physical and mental capabilities..."</p> <p>The Activity Director (AD) was interviewed on 7/21/14 at 10:25 a.m. During the interview, the AD indicated the facility provided two activities daily for the residents. The AD indicated on Thursdays, they offered three activities. The AD indicated the facility did not have a program for 33 of 75 demented residents. The AD indicated residents either attended the two daily activities or received one to one room visits from one of the five activity staff. The AD further indicated Resident #2 did attend activities but can't participate.4. The clinical record for Resident (1) was reviewed on 7/17/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to: severe intellectual disability,</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>dysphagia, abnormal posture and lack of coordination.</p> <p>On 7/16/14, Resident (1) was observed in his room with a thigh restraint on. He was again observed on 7/17/14 at 1:00 p.m. sleeping in his room in bed. On 7/18/14 at 9:25 a.m., Resident (1) was observed to be asleep in bed in his room. He was again observed in bed on 7/21/14 at 1:00 p.m.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 3/5/14, indicated Resident (1) was unable to complete the Brief Interview Mental Status (BIMS). Resident (1) had no speech, rarely understood, rarely understands with short and long term memory impairment. Resident (1) received the following Activities of Daily Living (ADL) assistance; transfer-total dependence with two person physical assist, ambulation-did not occur, dressing-total dependence with two person physical assist, hygiene and bathing-total dependence with one person physical assist.</p> <p>Review of a current care plan, dated 6/5/14, indicated the resident had a problem related to dependence on staff for activities due to physical limitations, cognitive stimulation, legally blind and</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>severe mental retardation. Approaches to this problem included, but were not limited to, 1 on 1 bedside visits in room and modify daily schedule, treatment plan as needed to accommodate activity participation. Resident (1) also had a problem related to physical restraints (thigh) related to severe mental retardation. Approaches to this problems included, but were not limited to, restraint-free time and physical activity daily.</p> <p>During review of the Activity Log for June and July, the one on one visits indicated the following room visits for Resident (1):</p> <p>June 1, 2014, June 23, 2014, July 7, 2014 and July 17, 2014.</p> <p>5. The clinical record for Resident (52) was reviewed on 7/17/14 at 10:54 a.m. The resident's diagnoses included, but were not limited to, psychosis, weakness, edema, hallucinations, congestive heart failure, dementia and dysphagia.</p> <p>During observation on 7/17/14 at 11:14 a.m. Resident (52) was asleep in her Broda chair. She was again observed on 7/18/14 at 9:25 a.m. asleep in bed. On 7/21/14 at 9:31 a.m., Resident (52) was asleep in bed.</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/14, indicated Resident (52) was unable to complete the Brief Interview Mental Status (BIMS). Resident (52) had no speech, rarely understood, rarely understands with short and long term memory impairment. Resident (52) received the following Activities of Daily Living (ADL) assistance; transfer-total dependence with two person physical assist, ambulation-did not occur, dressing-extensive assistance with two person physical assist, hygiene and bathing-total dependence with one person physical assist.</p> <p>Review of a current care plan, dated 5/22/14, indicated the resident had a problem with falls related to profound weakness and poor vision related to macular degeneration. Approaches to this problem included, but were not limited to: "encourage activity that promotes exercise, physical activity for strengthening and improved mobility."</p> <p>Another problem indicated Resident (52) preferred to stay in her room. Approaches to this problems included, but were not limited to: "one on one activity twice weekly and resident enjoys new beginning gospel group."</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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F000272 SS=D	<p>During review of the Activity Log for June and July, the one on one visits indicated the following room visits for Resident (52):</p> <p>June 1, 2014, June 23, 2014, July 7, 2014 and July 17, 2014.</p> <p>During an interview on 7/21/14 at 10:45 a.m., the Activity Director indicated Resident (1) and (52) received one on one activity twice weekly in their rooms. He indicated some of the activities included, but were not limited to, talking to the residents for a few minutes and rubbing or patting the resident's arm. He indicated the staff do not document the amount of time an activity occurred.</p> <p>3.1-33(a) 3.1-33(b)(8)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>						

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were completed for 1 of 1 residents. This failure was evidenced by accurate assessment for the use of a restraint for 1 of 1 residents reviewed for restraints. (Resident #1)</p> <p>Findings include:</p> <p>1. The clinical record for Resident (1) was reviewed on 7/17/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to: severe intellectual</p>	F000272	F-272The plan of correction for this deficiency will be to properly assess resident #1 for a restraint.Since all other residents who have restraints have the potential to be affected by this deficient practice all their MDS will be reviewed for proper coding and a proper assessment.The DON will be responsible for auditing and verifying that all restraints are coded and assessed correctly before signing off on the completeness of the MDS.Any newly ordered restraint will be audited by the DON for proper assessment and coding on the MDS.A list of all restraints/audits of proper	08/20/2014

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 07/21/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036		
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	<p>disability, dysphagia, abnormal posture and lack of coordination.</p> <p>On 7/16/14, Resident (1) was observed in his room with a thigh restraint on. He was again observed on 7/17/14 at 1:00 p.m. sleeping in his room in bed. On 7/18/14 at 9:25 a.m., Resident (1) was observed to be asleep in bed in his room. He was again observed in bed on 7/21/14 at 1:00 p.m.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 3/5/14, indicated Resident (1) was unable to complete the Brief Interview Mental Status (BIMS). Resident (1) had no speech, rarely understood, rarely understands with short and long term memory impairment. Resident (1) received the following Activities of Daily Living (ADL) assistance; transfer-total dependence with two person physical assist, ambulation-did not occur, dressing-total dependence with two person physical assist, hygiene and bathing-total dependence with one person physical assist. Resident #1 was not listed on the restraint section as having any type of physical restraint in place.</p> <p>Review of a current care plan, dated 6/5/14, indicated Resident (1) also had a problem related to physical restraints</p>		<p>assessment will be given to the administrator for our quarterly QA meeting. This will allow us to make changes or updates as necessary. All Nursing staff will be inservices on restraint assessments by the 20th of August to help ensure this deficient practice does not recurr.</p>		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>(thigh) related to severe mental retardation. Approaches to this problems included, but were not limited to: "evaluate the resident's restraint use quarterly, ensure the resident is positioned correctly with proper body alignment while restrained and apply when up in Broda chair and release every 2 hours. Document restraint use and release as per facility protocol."</p> <p>During an interview on 7/21/14 at 10:00 a.m., the Minimum Data Set (MDS) Coordinator indicated the resident was not listed on the MDS as having a restraint because he was unable to stand and she did not consider the thigh restraint as a restraint. She indicated the restraint kept the resident from sliding out of the chair.</p> <p>Review of a current facility policy date 6/12, titled "PHYSICAL RESTRAINT USE AND APPLICATION", which was provided by the Assistant Director of Nursing on 7/21/14 at 9:00 a.m., indicated the following:</p> <p>"POLICY: It is the policy of Community Parkview Care Center to prohibit the use of restraints for the purpose of discipline...</p> <p>ASSESSMENT/EVALUATION</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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F000282 SS=D	<p>1. Prior to initiation of a restraint, the licensed nurse will complete an assessment to ...</p> <p>...7. A restraint release record will be initiated to document that the resident is checked every 1 hour and release or repositioned every 2 hours."</p> <p>3.1-31(c)(6)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a resident was released from his thigh restraint in accordance with the resident's plan of care for 1 of 1 residents reviewed for restraints. (Resident 1)</p> <p>Findings include:</p> <p>The clinical record for Resident (1) was reviewed on 7/17/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, severe intellectual disability, dysphagia, abnormal posture and lack of coordination.</p>	F000282	F282Resident #1 will be checked every hour and released every 2 hours per the facility policy regarding restraints. Since all other residents who have restraints have the potential to be affected by this deficient practice, the facility will identify all other residents with restraints and check and release every 2 hours per facility policy. All residents with restraints will be checked every day for 30 days then 3 days a week for 30 days and weekly thereafter. This will remain in effect weekly to help ensure this deficient practice does not recur. The checks will take place at	08/20/2014			

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>On 7/16/14, Resident (1) was observed in his room with a thigh restraint on. He was again observed on 7/17/14 at 1:00 p.m. sleeping in his room in bed. On 7/18/14 at 9:25 a.m., Resident (1) was observed to be asleep in bed in his room. He was again observed in bed on 7/21/14 at 1:00 p.m.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 3/5/14, indicated Resident (1) was unable to complete the Brief Interview Mental Status (BIMS). Resident (1) was severely cognitively impaired.</p> <p>Review of a current care plan dated, 6/5/14, indicated Resident (1) also had a problem related to physical restraints (thigh) related to severe mental retardation. Approaches to this problems included, but were not limited to: "evaluate the resident's restraint use quarterly, ensure the resident is positioned correctly with proper body alignment while restrained and apply when up in Broda chair and release every 2 hours. Document restraint use and release as per facility protocol."</p> <p>During an interview on 7/17/14 at 1:22 p.m., CNA #5 indicated the resident's restraint was released approximately</p>		different times during the day to ensure compliance on all shifts. Results of the audits will be completed by the DON or their designee and given to the Administrator for our quarterly QA meeting to review for updated or changes. All Nursing Staff will be inserviced on the policy and procedure for restraints by the 20th of August, 2014.				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>three times a shift.</p> <p>During an interview on 7/17/14 at 1:32 p.m., CNA #12 indicated the resident was released from his restraint between 8-8:30 a.m. and again between 12:30-1:00 p.m. She indicated she had not yet charted in the restraint log today when the resident was released.</p> <p>During an interview on 7/21/14 at 1:54 p.m., CNA #12 indicated she worked Monday thru Friday and had a schedule with Resident (1). She indicated she was the CNA taking care of Resident (1) today and had not yet charted in the restraint log. She indicated she does it at the end of her shift.</p> <p>During review of the restraint log on 7/17/14 at 1:30 p.m., no documented times were noted on 7/17/14 as to when the resident was unrestrained or restrained in his chair.</p> <p>During review of the restraint log on 7/21/14 at 11:00 a.m., no documented times were noted after 7/19/14 at 10:00 p.m. as to when resident was unrestrained or restrained in his chair.</p> <p>Review of a current facility policy date 6/12, titled "PHYSICAL RESTRAINT USE AND APPLICATION", which was</p>			

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F000311 SS=D	<p>provided by the Assistant Director of Nursing on 7/21/14 at 9:00 a.m., indicated the following:</p> <p>"POLICY: It is the policy of Community Parkview Care Center to prohibit the use of restraints for the purpose of discipline...</p> <p>ASSESSMENT/EVALUATION</p> <p>1. Prior to initiation of a restraint, the licensed nurse will complete an assessment to ...</p> <p>...7. A restraint release record will be initiated to document that the resident is checked every 1 hour and release or repositioned every 2 hours."</p> <p>3.1-35(g)(1)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview, and record review, the facility failed to ensure nail care was provided for 1 of 50 residents dependent on staff for hygiene. (Resident #18)</p>	F000311	F-311The plan of correction for this deficiency is to cut resident #18s thumb nail.The residents physician visited the facility and has cut the residents thumb nail.Since other residents have	08/20/2014

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>Findings Include:</p> <p>During the noon meal observation on 7/15/14 at 11:45 a.m. Resident #18 was observed. The resident's left thumb nail was observed to be 1/4 inch long, yellow, and thick. The resident wore hand splints on both hands.</p> <p>The clinical record of Resident #18 was reviewed on 7/17/14 at 1:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, Alzheimer's Dementia and Atherosclerosis.</p> <p>The care plan, dated 6/19/14, indicated Resident #18 was dependent on staff for all Activities of Daily Living.</p> <p>CNA #3 was interviewed on 7/18/14 at 10:00 a.m. During the interview CNA #3 indicated the CNAs cut all the residents' nails except for the thumb nail. The CNA indicated nurses cut Resident #18's thumb nail because it's so thick.</p> <p>LPN #1 was interviewed on 7/18/14 at 2:00 p.m. During the interview, the nurse indicated she was not sure who cut Resident #18's thumbnail. The nurse indicated the nail was long and calloused. LPN #1 further indicated she could not</p>		<p>the potential to be affected by this deficient practice all Nursing Staff will be inserviced on nail care at the facility and the need to notify the physician of any nails that the staff is unable to trim or cut. The facility will comlet a physical round of all residents and document and notify the physician of any nails we are unable to cut or trim. Any new residents will have a nursing assessment and staff will note nails that need trimming or cutting that the physician might need to do. All nursing staff will be inserviced on proper nail care and who to notify for trimming or cutting of nails. The DON or their designee will be responsible for checking 10 residents nails a week to ensure this deficient practice does not recurr. The results of these audits will be given to the administrator at our quarterly QA for review and updateds or changes as needed.</p>				

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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F000314 SS=D	<p>find any documentation on the treatment record or any schedule related to caring for Resident #18's nail.</p> <p>LPN #4 was interviewed on 7/18/14 at 2:55 p.m. During the interview, the nurse indicated the podiatrist cuts the resident's thumbnail with a drummel. The nurse indicated the podiatrist visits the facility every couple of weeks and she would put the resident's name on the podiatrist list.</p> <p>The Assistant Director of Nursing (ADoN) was interviewed on 7/18/14 at 3:00 p.m. The ADoN indicated the resident's thumb nail was 1/4 inch long, yellow and thick.</p> <p>Further review of Resident #18's clinical record, on 7/18/14 at 3:15 p.m., indicated the resident's last podiatry visit was 1/24/14. The note made no mention of the thumb nail.</p> <p>A Physician Progress note, dated 6/3/14, indicated "...long, calloused nail..."</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>						

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure pressure sore treatment was completed as evidenced by turning and repositioning for 1 of 2 residents reviewed with pressure sores. (Resident #76).</p> <p>Findings Include:</p> <p>During the Initial Tour on 7/15/14 at 9:15 a.m., Resident #76 was observed laying on his back in a bed with an air mattress.</p> <p>The resident was again observed in the bed on his back on 7/15/14 at 10:00 a.m., 11:15 a.m., 12:45 p.m., 2:00 p.m., 3:00 p.m., and 4:00 p.m.</p> <p>Resident #76 was observed in bed, on his back on 7/16/14 at 8:30 a.m., 9:30 a.m., 10:30 a.m., 12:30 p.m., 1:00 p.m., 2:30 p.m., and 3:00 p.m.</p> <p>Resident #76 was observed on his back, in bed on 7/17/14 at 8:30 a.m., 10:00 a.m., 11:00 a.m., 12:45 p.m., 1:00 p.m., and 2:00 p.m.</p>	F000314	F-314The plan of correction for this deficiency will be to turn resident #76 every 2 hours to help prevent heal pressure sores. Since all residents with pressure sores requiring treatment have the potential to be affected by this deficient practice they will also be turned every 2 hours per facility policy to help heal/prevent pressure sores.The Director of Nursing or their designee will be responsible for checking residents to ensure turning is taking place.All residents affected will be checked every day for the first 30 days and the 3times a week for 30days and every week thereafter. This will remain ongoing to ensure this does not recurr.The audits will take place at different times during the day to ensure all shifts are covered.The turning documentation will also be added to our electronic documentation making it readily available for our staff to document.All nursing staff will be inserviced by the 20th of August on our policy to turn residents for pressure relief.The results of all audits will be included in our quarterly QA for updates and needed changes.	08/20/2014

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>Resident #76 was observed on his back in bed on 7/18/14 at 8:30 a.m., 10:30 a.m., 11:30 a.m., 2:15 p.m., and 3:00 p.m.</p> <p>The clinical record of Resident #76 was reviewed on 7/18/14 at 11:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, depressive disorder, anxiety state, esophageal reflux, pressure ulcers, and heart disease.</p> <p>Physician orders, signed on 6/30/14, included may participate in activities as tolerated, bedrest, and hospice.</p> <p>The care plan, dated 6/26/14, indicated Resident had open areas on the coccyx related to immobility and incontinence. The care plan interventions included a low air loss mattress and treatments. The care plan indicated the resident was totally dependent on staff for turning in bed, transfers, hygiene, and bathing. The resident was fed by a gastrostomy tube.</p> <p>The resident's pressure sore, on the coccyx, was observed on 7/17/14 at 3:45 p.m. with the facility wound nurse and LPN #11.</p> <p>The facility wound nurse was interviewed on 7/17/14 at 3:55 p.m. During the</p>			

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 07/21/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F000323 SS=D	<p>interview, the wound nurse indicated Resident #76 was turned every two hours by staff to promote healing and prevent further skin breakdown.</p> <p>The undated facility policy entitled,"PRESSURE ULCER/SKIN CONDITION REPORT POLICY" was provided by the DoN on 7/21/14 at 2:15 p.m. The policy indicated, " ...6. The resident will be assessed for any interventions that may be beneficial to the wound healing - mattress, cushions, turn schedule, dietary interventions...."</p> <p>Further information was requested of the DoN regarding the lack of turning for the pressure sore treatment of Resident #76 on 7/21/14 at 2:15 p.m.</p> <p>No further information was provided.</p> <p>3.1-40(a)(2)</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 ensure</p>	F000323	F323The plan of correction for this deficiency will be to ensure that resident #52 be provided with	08/20/2014

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>residents were provided with a Personal Alarm Device (PAD) following a fall as prescribed by the physician. This deficient practice had the potential to affect 1 of 3 residents reviewed for accidents. (Resident 52)</p> <p>Findings include:</p> <p>The clinical record for Resident (52) was reviewed on 7/17/14 at 10:54 a.m. Diagnoses included, but were not limited to, psychosis, weakness, edema, hallucinations, congestive heart failure, dementia and dysphagia.</p> <p>During observation on 7/17/14 at 11:14 a.m., Resident (52) was asleep in her Broda chair in her room. No chair alarm was observed. She was again observed on 7/18/14 at 9:25 a.m. asleep in bed. No bed alarm was observed.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/14, indicated Resident (52) was severely cognitively impaired.</p> <p>Review of a current care plan, dated 5/22/14, indicated the resident had a problem with falls related to profound weakness and poor vision related to macular degeneration. Approaches to this problem included, but were not</p>		<p>a personal alarm as ordered by the physician. Since all other residents who have personal alarms have the potential to be affected by this deficient practice the facility will ensure that all residents who have an order for a personal alarm have that alarm in place as ordered. The facility will keep an updated list of all residents with orders for alarms and will check those residents daily for 30 days then 3 times a week for 30 days and weekly thereafter to ensure that personal alarms are in place. The director of nursing or their designee will be responsible for the checks and will provide the results to the administrator for review at our QA meeting to make any needed changes or update. All nursing staff will be inserviced and the policy reviewed and changed if needed. This will be completed by the 20th of August, 2014.</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>limited to: "ensure the resident is wearing appropriate footwear, check on resident every 15 minutes and call light in reach."</p> <p>During a staff interview on 7/16/14 at 9:53 a.m., LPN #14 indicated Resident (52) had fallen over the weekend. She indicated the resident was sent to the hospital with only mild bruising.</p> <p>During an interview on 7/17/14 at 1:32 p.m., CNA #12 indicated the resident was no longer on 15 minute checks and did not have any alarms.</p> <p>During an interview on 7/18/14 at 9:00 a.m., the Assistant Director of Nursing (ADoN) indicated 15 minute checks had been discontinued, but were still listed on the care plan. She indicated the alarms were recently discontinued just prior to the recent fall.</p> <p>During an interview on 7/18/14 at 9:34 a.m., LPN #14 indicated the resident did not have any alarms.</p> <p>During an interview on 7/18/14 at 9:47 a.m., the ADoN indicated she was under the impression following the most recent fall, Resident (52) had an alarm in place. She indicated the physician was faxed an order to reapply the alarm.</p>						

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 07/21/2014
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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
F000329 SS=D	<p>During review of the post fall investigation, dated 7/13/14 at 10:35 a.m., which was provided by the ADoN on 7/18/14 at 9:00 a.m., indicated the following:</p> <p>"INTERVENTION (S): Personal alarm to alert staff."</p> <p>During review of a fall statement, the staff member indicated the Physician was notified and a new order for a personal alarm was received. The statement was signed by the ADoN on 7/14/14.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and</p>			

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

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to attempt a gradual dose reduction or to obtain a letter from the Physician stating a gradual dose reduction was clinically contraindicated for psychoactive medications for 2 of 5 residents reviewed for unnecessary medications. (Residents #3 and #48)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 7/18/14 at 10:21 a.m. Current diagnoses included, but were not limited to, Gillian-Barre syndrome with residual quadriparesis, hypertension, anemia, congestive heart failure, atrial fibrillation and flutter, depressive type psychosis, edema, insomnia, morbid obesity, bipolar disorder, depressive disorder, schizoaffective disorder chronic with acute exacerbation, delusional disorder, protein-calorie malnutrition and anterior horn cell disease.</p> <p>The resident was currently receiving, on a daily basis, Zoloft (antidepressant) 150 milligrams by mouth every day. It was originally ordered on 2/15/13 for a diagnosis of psychotic depression.</p>	F000329	F329 The plan of correction for this deficiency will be to attempt a gradual dose reduction or to obtain a letter from the physician stating that the GDR was contraindicated for the residents involved. Since all other residents that require a GDR have the potential to be affected by this deficiency, the facility will review all records of residents receiving psychoactive medications and assure a GDR has been attempted or a letter from the physician has been received. The DON or their designee will be responsible for reviewing records at our behavior meetings and verifying that the documentation is provided documenting a GDR or a physicians contraindication. These audits will be provided as part of our quarterly QA for reviews and updates. All staff involved will be inservices on the policy and procedureCommunity Parkview Care Center is requesting an IDR/Explanation is Attached	08/20/2014

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 07/21/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

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	<p>The chart indicated no Gradual Dose Reduction (GDR) or letter of contraindication had been completed on Zoloft, being used as a antidepressant since the original order date of 2/15/13.</p> <p>During an interview with the Pharmacy Consultant on 7/21/14 at 1:00 p.m., she indicated the physician does not come to the "Behavior Team" meetings. The Pharmacy Consultant indicated the "Behavior Team" makes recommendations and the physician either agrees or disagrees based on the recommendations for psychoactive medications that include antipsychotic, antidepressant and antianxiety medications. She indicated the medication Zoloft (antidepressant) had not been decreased because the focus first was on antipsychotic medications, because there was more chance of severe side effects.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 7/21/14 at 3:30 p.m., she indicated no contraindication letters or attempts at a GDR since the order was increased on 2/15/14 for Zoloft (antidepressant) medication had been attempted.</p> <p>No further documentation was provided</p>			

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 07/21/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

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	<p>by the facility as of exit 7/21/14.</p> <p>2. Resident #48's clinical record was reviewed on 7/17/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, anxiety state and depression.</p> <p>The resident had a current order for Zoloft (an anti-depression medication) 100 milligrams (mg) by mouth daily for depression. The orders indicated the Zoloft order had originated on 2/15/13. The Zoloft dosage was increased on 4/10/14 from 50 mg by mouth daily to current dose of 100 due to 5 episodes of "frequent crying" in March of 2014 and listed on the "Behavior Detail Report" and documented in the "Progress Notes". No Gradual Dose Reduction (GDR) of the Zoloft was found and the dosage increase was not ordered until 14 months after drug initiation.</p> <p>During an interview with the Social Service Director on 7/21/14 at 11:15 a.m., she indicated they did not have a resident specific contraindication letter for the Zoloft from the Physician with a justification for not attempting a gradual dose reduction.</p> <p>During an interview with the Pharmacy Consultant on 7/21/14 at 12:47 p.m., she indicated they had been working on</p>			

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 07/21/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
	<p>decreasing other medications before decreasing the Zoloft. She indicated the regulations did not stipulate the Physician had to write a resident specific contraindication letter. They use the "team notes" and the Physician agrees upon those recommendations and signs those notes.</p> <p>An undated policy "GRADUAL DOSE REDUCTIONS FOR PSYCHOTROPIC MEDICATIONS", provided by the Assistant Director of Nursing (ADoN) on 7/21/14 at 1:45 p.m., indicated;</p> <p>"Gradual dose reductions for anti-psychotic, anti-depressants, anxiolytics, and mood stabilizing medications will be evaluated twice the first year. The attempts to reduce the medication will be in two separate quarters, with at least one month in between attempts, then annually thereafter. Sedative and hypnotics will be evaluated quarterly for attempts to reduce these medications.</p> <p>Any other medications given to address mood or behavioral symptoms will also be evaluated for reduction twice the first year, with attempts being made in two separate quarters, with one month in between attempts and then annually thereafter.</p>			

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>The psychotropic agent associated with the greatest risk of adverse drug reactions will be addressed first. Reducing multiple psychotropic medications at a single time is often inappropriate and increases difficulty in the ability to determine which agent is the cause of the failed reduction."</p> <p>3.1-48(b)(2)</p> <p>Facility information / determination: The facility submitted information from the pharmacy that indicated the Pharmacist was very upset with the surveyor ' s interviews of her. The Pharmacist indicated the surveyors said the following:</p> <ul style="list-style-type: none"> · They should obtain the " form used by Omnicare " and indicated their form was much better; · The term " clinical contraindication " was not on the form; · The physician must personally write the " clinical contraindication statement " and that a check box was not adequate; · Psychopharmacological medication needs to be addressed 						

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>separately vs. therapy being reviewed as a whole.</p> <p>Surveyors should be careful not to be misunderstood they are acting as a "consultant". The surveyor should ask about the facility's system and track it to assess if they are meeting the intent of the regulation.</p> <p>In this case, since the physician was not involved in the meetings, it would have made the tag stronger to interview the physician and see how much he knew about the specific residents and if he had written any progress notes to support his position.</p> <p>Resident #3--- the orders presented from the facility were: 8/10/12-Xanax 0.5 mg QHS 11/20/12--Xanax 0.25 mg QHS (reduction) 1/3/14-Xanax 0.25 mg QHS 2/4/14-Xanax 0.25 mg tid (increase x 3)</p> <p>2/15/13-Zoloft 50 mg QD 3/19/13-MD declined to decrease Xanax 4/2/13-Zoloft 100mg QD (increase) The 2567, in the second paragraph of the finding, indicated the current dose of Zoloft was 150 mg. which was initiated on 2/15/13. The facility did not address the Zoloft 150 mg., only the increase to the 100 mg.</p>						

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>The " facility reasons " for increase dosage was the resident was trying to transfer herself daily and also would raise her cane to strike someone. These " reasons " were not expounded upon by the facility and there was no indication as to WHY she was trying to transfer herself or why she wanted to hit someone with her cane. There was no psych eval or any other evaluation to show assessment or investigation into the resident ' s behaviors.</p> <p>There was no statement submitted as to why the physician wanted the drug increased and why the resident has stayed on this dose.</p> <p>The pharmacist indicated they look at the drugs as a " whole " ; however it did not meet the intent of the regulation for gradual dose reduction for an attempted antidepressant reduction.</p> <p>No information was submitted for the second resident.</p> <p>The 2567 DPS indicated the facility did not obtain a " letter from the physician " . This phrase will be replaced with documentation from the physician. Further in the finding, " letters " are again addressed and will be changed to documentation.</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>REASON FOR DECISION: Page 36, 3rd line of the DPS, " a letter " will be changed to " documentation " ; page 37, the last full paragraph, the 4th sentence, " letters " will be changed to " documentation " ; page 38, last full paragraph, 4th line, " letter " will be changed to " documentation " . Otherwise the remainder of the tag will be the same.</p> <p>The facility did not submit sufficient information to show:</p> <ul style="list-style-type: none"> · They attempted dosage reduction after the last increase in medication; · Adequate indications for use; · Physician documentation of why the dosages were clinically appropriate; · Evidence of assessment of behaviors, before drugs were increased; · They followed their policy for dose reduction. <p>SUPERVISOR NAME:</p> <p>_____</p> <p>Susie Scott, RN</p>			
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F000353 SS=F	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to provide sufficient nursing and CNA staff to meet the needs of residents related to basic care, potentially affecting 75 of 75 residents who reside in the facility.</p> <p>Findings include:</p> <p>During a family interview on 7/16/14 at 12:59 p.m., family for Resident #90 indicated she had seen on several</p>	F000353	The plan of correction will be to ensure the facility has sufficient staffing to meet the basic needs of the residents. To ensure staffing is adequate to meet the needs of the residents the facility will monitor the staffing and the call ins every day every shift. The Administrator or their designee will be responsible for coordinating with the nursing scheduling coordinator to pre plan the number of staff required for each shift. The facility has recently hired cnas to cover shifts	08/20/2014

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 07/21/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036		
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	<p>occasions when there was no one in the hallway except a staff person passing medication on Ivy Court. The family member stated on 7/13/14 at approximately 1:30 p.m., she told the nurse her mother had to use the bathroom and the nurse told her that they had already taken her to the rest room 5 times that day and did not offer to assist the resident. The nurse also had indicated two other staff were with other residents.</p> <p>During an interview on 7/16/14 at 8:38 a.m., Resident #66 indicated she had to wait 20 to 30 minutes to have her call light answered and she has had an incontinent episode while waiting for her call light to be answered.</p> <p>During an interview on 7/18/14 at 2:40 p.m., CNA #5 indicated the staff worked short most days. CNA #7 indicated they go without breaks to get their work done. This was normal staffing on the weekends.</p> <p>During an interview on 7/18/14 at 2:47 p.m., Qualified Medication Aid (QMA) #6 indicated they worked short most of the time. The staff worked short about 3 days a week. They try and call people in, but they only get someone to fill in about 1 of those days a week. This has been going on for a few months.</p>		<p>where employees had quit. The facility will pull the resident and condition report weekly and staff employees according to the acuity of the different hallways. The facility will also have an on call staff member that will be responsible for calling in to see if they are needed to work that day. The on call staff will be available on the weekends along with the Weekend department head manager to help cover shifts and verify that staff is adequate to meet the needs of the residents. The facility will come up with a minimum staffing ratio that is acceptable so that the charge nurses are aware of when someone is needed to call in to work. The schedules along with any changes and total hours worked will be given to the administrator to verify sufficient staffing. All information will be presented at our quarterly QA for review and updates. Changes will be made as needed to ensure sufficient staffing. All nursing staff will be in-serviced on staffing patterns and minimum staffing required to meet the needs of the residents.</p>		

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

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	<p>During an interview on 7/18/14 at 3:10 p.m., LPN #7 indicated she had worked short at least once a week. She had been texted by management at least 3 times a week to come in and work. LPN #7 indicated she told management about an evening, the date she did not remember, where the residents were not getting turned and call lights were not getting answered in a timely manner. Management told her they would address that issue, but had not heard anything since logging her complaint.</p> <p>During an interview on 7/18/14 at 3:28 p.m., CNA #8 indicated they worked short most shifts. CNA #2 indicated she came in on most of her days off to fill in and help. She felt their charting was lacking due to not having the time to get it done.</p> <p>During an interview on 7/18/14 at 3:40 p.m., QMA #9 indicated they worked short most evenings. She got pulled from working as a QMA and worked as a CNA at least 1 shift per week out of the 3 shifts she worked per week.</p> <p>During an interview on 7/18/14 at 3:52 p.m., CNA #10 indicated they worked short most nights she worked. She indicated they worked with 3 to 4 CNA's</p>			

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

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	<p>for the entire building on more than one occasion.</p> <p>During an interview on 7/21/14 at 1:20 p.m., Resident #47 indicated she had to wait up to 30 minutes at a time for her call light to be answered and at other times she couldn't find anyone in the hall or at the nurses station because they were in a room with another resident or all in the dining room serving trays. This happened every day.</p> <p>During an interview on 7/21/14 at 1:30 p.m., Resident #66 indicated she had to wait for 30 to 40 minutes to get her call light answered at times and routinely waited 15 minutes. This happened every day.</p> <p>During an interview on 7/21/14 at 1:40 p.m., Resident #3 indicated she had to wait 15 to 30 minutes to get her call light answered through the week and on the weekends it was 30 to 45 minutes. The weekends seemed like a "ghost town" at times due to seeing so few staff.</p> <p>During an interview on 7/21/14 at 1:45 p.m., Resident #12 indicated she had to wait 15 to 30 minutes to get her call light answered at least 3 times a week and on most weekends.</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>During a review of the Resident Council Minutes on 7/21/14 at 10:00 a.m., the 1/14/14 minutes indicated 4 complaints by residents of taking a long time for staff to answer call lights.</p> <p>During an interview on 7/21/14 at 2:46 p.m., the DoN and the Activity Director indicated they had no information showing they addressed the lack of staffing complaints voiced in the Resident Council Minutes of 1/14/14.</p> <p>During an interview on 7/21/14 at 3:20 p.m., the Nursing Department Scheduler indicated how many nursing hours she staffs was dependent on census. She did not go by acuity. The facility would like to have 5 CNA's plus a Shower aid staffed for Lilac and Redbud Lane and 3 CNA's and a Shower aid staffed for Ivy Court on day shift, 2 CNA's on Lilac Lane, 3 CNA's on Redbud Lane and Ivy Court for evenings and 1 CNA on Lilac Lane and 1 CNA on Redbud Lane and 2 CNA's on Ivy Court for night shift. The staff on the floor then divides up the staffing according to the acuity of the residents. The Nursing Department Scheduler indicated they are usually down by 2 to 3 CNA's on a daily basis and day shift has had 5 to 6 CNA's for the entire building on a daily basis for the last 2 weeks due to vacations, staff</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>quitting and call off's.</p> <p>Review of the last 2 months of Daily Staffing Sheets provided by the ADoN on 7/18/14 at 1:30 p.m., indicated 4 CNA's were assigned to the day shift on 6/29/14. 5 CNA'S were assigned on 6/21/14 and 7/13/14. 6 CNA's were assigned on 6/1/14, 6/8/14, 6/15/14, 6/22/14, 7/8/14. The scheduler had planned on 9 CNA's.</p> <p>During the evening shift 4 CNA's were assigned on 7/13/14. 5 CNA's were assigned on 6/1/14, 6/30/14 and 7/11/14. 6 CNA's were assigned on 6/13/14, 7/8/14 and 7/9/14. The scheduler had planned for 5 CNA's.</p> <p>During the night shift 2 CNA's were assigned on 7/6/14. 2 CNA's after 3:00 a.m. were assigned on 6/30/14, 7/8/14 and 7/9/14. The scheduler had planned for 3 CNA's.</p> <p>Review of the "Census and Conditions of Residents" form, completed by the facility, indicated 57 residents required assist of one or two staff for bathing, 58 residents required assist of one or two staff for dressing, 46 residents required assist of one or two staff for transferring, 41 residents required assist of one or two staff for toilet use. Review of CNA</p>						

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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

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F000356 SS=C	<p>assignment sheets for each hall indicated 3 residents on Redbud Lane required "bari-lift only (3 assist) w/c".</p> <p>3.1-17(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law,</p>			

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 07/21/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F000364 SS=D	<p>whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 1 of 5 days of the survey (7/15/14). This practice had the potential to affect 75 of 75 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour on 7/15/14 at 8:50 a.m., the nursing staff information was not found to be posted.</p> <p>During an interview with the Director of Nursing (DoN) on 7/15/14 at 9:23 a.m., she indicated the posting was not posted and had not been posted since they started painting and they had forgotten to start posting the staffing information when the painting was complete.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview and record review,</p>	F000356	F-356Since no residents were harmed by not posting the staffing the facility will ensure that the staffing is posted daily.The posting of staffing hours was posted for every day of the survey and has been since that day.The facility will post the hours daily and the DON or their designee will be responsible for checking the daily postings and signing off that they have been posted.The completed signed postings will be given to the administrator for verification and included in our quarterly QA for any changes or updates that need made.All staff responsible for postings will be inserviced by the 20th of August, 2014.	08/20/2014
		F000364	F-364The plan of correction for f 364 will be to ensure that resident	08/20/2014

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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	<p>the facility failed to ensure food was served at a palatable temperature and overall quality of taste for 2 of 3 residents interviewed for food quality. (Residents 55 and 66)</p> <p>Findings include:</p> <p>1. During an interview on 7/16/14 at 9:00 a.m., Resident (55) indicated the food was not good. She indicated she does not like the food the facility served. She indicated she would often order sandwiches instead of meals.</p> <p>During an interview again on 7/21/14 at 8:30 a.m., Resident (55) indicated she ordered food the facility could not mess up.</p> <p>2. During an interview on 7/16/14 at 8:37 a.m., Resident (66) indicated the food was nasty all the time.</p> <p>During an interview again on 7/21/14 at 11:00 a.m., Resident (66) stated the food had no taste and was always served cold. She indicated substitutes were available, but tasted no better.</p> <p>3. During meal service observation on 7/18/14 at 11:33 a.m., Cook #2 checked the temperature of the food to be served</p>		#55 and #66 (this resident discharged home), receive food that is palatable, attractive and the proper temperature. Since all residents have the potential to be affected by this deficient practice the facility will ensure that all residents will receive a palatable meal at the proper temperature. All residents or family members will be surveyed initially to address concerns associated with dietary. All concerns will be taken to QA and addressed with a process for improvement. Residents will again be surveyed randomly throughout the improvement process and results documented. 10 residents will be surveyed regarding food quality and temperatures on a weekly basis ongoing. This will help to ensure this deficient practice does not recur. All dietary staff will be updated on calibrating a thermometer and taking food temperatures at every meal service. Food service surveys will be made available to families and residents at a central location within the facility. This will allow concerns to be taken at all times. All surveys and daily temperature logs will be taken to our QA for review and updates. Changes will be made according to concerns and procedure changes to make residents satisfied with meal service. All staff will be inserviced on meal service surveys and how				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036		
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	<p>at lunch. The following was observed:</p> <p>Pureed ham salad on a croissant was 71 degrees Fahrenheit (F).</p> <p>Macaroni salad was 73 degrees F.</p> <p>Vegetable soup was 172 degrees F.</p> <p>Chicken patty sandwich was 135 degrees F.</p> <p>High calorie pudding was 54 degrees F.</p> <p>Cottage cheese was 47.5 degrees F.</p> <p>Chocolate milk was 40.8 degrees F.</p> <p>Honey thickened milk was 50 degrees F.</p> <p>Ranch dressing was 45.7 degrees F.</p> <p>French dressing was 49.4 degrees F.</p> <p>Shredded cheese was 49.5 degrees F.</p> <p>Diced eggs were 47.3 degrees F.</p> <p>During an interview on 7/18/14 at 12:20 p.m., Cook #2 indicated she was unsure why the serving temperatures were not at the proper temperature. She indicated the food would be thrown away.</p> <p>Review of a current facility policy, dated 3/15/02, titled "Food Storage", which was provided by the Director of Nursing on 7/21/14 at 2:31 p.m., indicated the following:</p> <p>"Policy: Food supplies will be properly stored in accordance with good sanitary practices.</p> <p>FOOD TEMPERATURES</p>		to report concerns to our QA.		

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 07/21/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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F000371 SS=F	<p>...6. Acceptable temperature standards at serving time are as follows: Meats, Entrees, Casseroles >140 degrees but preferably 160-175F. Cold salad/s desserts <41 degrees but preferably 35 degrees F. Cold Beverages: Milk, Juice <41 degrees but preferably 35 degrees F. Cakes, Pastries 60 degrees F. ...7. Food items that do not meet acceptable levels and cannot be corrected in time for meal service will not be served and an appropriate substitution is to be made." 3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure the food was stored, prepared and distributed under sanitary conditions. Of the facility's 75 resident's, this deficient practice had the potential to impact 73 of</p>	F000371	F-371The plan of correction for this deficiency will be to ensure that food is stored,prepared and ditributed under sanitary conditions.The facility will review and re-inservice all dietary staff regarding the policy.The Dietary manager or their designee will be responsible for monitoring and	08/20/2014			

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	<p>73 residents who were served food from the facility's kitchen.</p> <p>Findings include:</p> <p>1. The kitchen sanitation tour was accompanied by the Dietary Manager on 7/15/14 at 8:50 a.m. The following concerns were noted:</p> <p>a. Barbeque sauce, which was stored in the three door stainless steel refrigerator, did not have a cap but was covered with torn foil, which did not prevent food contamination.</p> <p>b. Vanilla mousse, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>c. Cherry cheesecake, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>d. Watermelon, which was stored in the three door stainless steel refrigerator, was covered with torn foil and was dated 7/8/14, which did not prevent food contamination.</p> <p>e. Sausage, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>f. Diced ham, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p>		<p>verifying that:1.Food is dated and stored properly.2.Food received is dated with received date3.Temperatures are taken and are served at proper temperatures.4.Pans and utensils are stored properly5.Walls and floor are kept cleanAll of the above concerns will be checked for accuracy on a daily basis and a record kept by the dietary manager or their designee.This will take place daily for 30days, then 3x a week for 1 month and weekly thereafter. This will exclude the temperatures which will take place at every meal.The adminstrator will spot check the dietary concerns twice a week and share the report with the dietary manager for follow up or review.All records of audits will be given to the administrator for follow up or review at our quarterly QA meeting.All Dietary staff will be inserviced on Dating food, Food storage, Cleaning, Utensil and pot and pan storage. This inservice will take place by August the 20th 2014.</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>g. Fruit cocktail, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>h. Ham, which was stored in the three door stainless steel refrigerator, with a date of 7/5/14.</p> <p>i. Lemon pie, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>j. Sliced turkey, which was stored in the three door stainless steel refrigerator, with an open date of 7/5/14.</p> <p>k. Hard boiled eggs in 4 packages, which was stored in the three door stainless steel refrigerator, did not have a date opened.</p> <p>l. The inside of the stainless steel refrigerator had multiple spills of dried food and liquids on the bottom of the refrigerator. The outside of the refrigerator had food particle smudges.</p> <p>m. On a preparation area, a box of napkins was saturated on the bottom of the box.</p> <p>n. On a preparation area, a box of thickened liquid was saturated on the bottom of the box related to a broken container in the bottom of the box.</p> <p>o. In a container of coffee, a measuring</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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	<p>scoop was left inside the container.</p> <p>p. In the small refrigerator, an open bottle of catsup, a bottle of mustard, a container of apple juice, a container of fruit punch, a cup of milk, 2 containers of cottage cheese, a pitcher of iced tea and a carafe of milk did not have a date opened.</p> <p>q. A total of 8 stainless steel pots were not observed upside down to prevent contamination and stored on a shelf near the exit door.</p> <p>r. The dry storage rooms contained the following cans, bottles and jars with no received date: 8 bottles of salad dressing, 4 jars of mayonnaise, 2 jars of salsa, 2 bottles of vegetable oil, 17 jars of broth, 2 jars of peanut butter, 9 cream of chicken soup, 4 cream of mushroom soup and 78 gallon cans of prepared food items. This made rotation of old/new cans difficult.</p> <p>s. The walls and floor throughout the kitchen and storage area had food and debris and grime on them.</p> <p>2. During meal service observation on 7/18/14 at 11:33 a.m., Cook #2 checked the temperature of the food to be served at lunch. The following was observed: Pureed ham salad on a croissant was 71</p>			

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	<p>degrees Fahrenheit (F).</p> <p>Macaroni salad was 73 degrees F.</p> <p>Vegetable soup was 172 degrees F.</p> <p>Chicken patty sandwich was 135 degrees F.</p> <p>High calorie pudding was 54 degrees F.</p> <p>Cottage cheese was 47.5 degrees F.</p> <p>Chocolate milk was 40.8 degrees F.</p> <p>Honey thickened mild was 50 degrees F.</p> <p>Ranch dressing was 45.7 degrees F.</p> <p>French dressing was 49.4 degrees F.</p> <p>Shredded cheese was 49.5 degrees F.</p> <p>Diced eggs was 47.3 degrees F.</p> <p>During an interview on 7/15/14 at 9:30 a.m., the Dietary Manager indicated the following:</p> <p>She was embarrassed by the way the kitchen looked. She indicated the staff were to date every item when it was delivered to the facility. She also indicated that food in the refrigerators were only good for seven days and then should be tossed after day 7.</p> <p>During an interview on 7/18/14 at 12:20 p.m., Cook #2 indicated she was unsure why the serving temperatures were not at the proper temperature. She indicated the food would be thrown away.</p> <p>Review of a current facility policy date</p>				

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	<p>3/15/02, titled "Food Storage", which was provided by the Director of Nursing on 7/21/14 at 2:31 p.m., indicated the following:</p> <p>"Policy: Food supplies will be properly stored in accordance with good sanitary practices.</p> <p>PROCEDURE:</p> <p>Dry Food Storage Principles</p> <p>...4. The walls, ceiling, floor and shelving shall be maintained in good repair and regularly cleaned.</p> <p>...5. Opened packages shall be stored in closed containers, labeled and dated.</p> <p>...9. ...Scoops used for bulk food items are not stored in food containers...</p> <p>...11. Stock shall be rotated so that the oldest items are used first. FIFO method is followed...</p> <p>REFRIGERATED STORAGE PRINCIPLES</p> <p>...3. All walk-in freezers and refrigerators shall be properly lighted and clean.</p> <p>...7. Leftovers are refrigerated immediately and used according to the "Leftover" policy. The food items shall be covered, labeled and dated.</p> <p>...12. All food items in refrigerators shall</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F000520 SS=F	<p>be properly dated, labeled, and placed in clean containers with lids, or loosely wrapped.</p> <p>FRESH FRUITS AND VEGETALBES ...7. Use fresh fruit within 3-7 days.</p> <p>FOOD TEMPERATURES ...6. Acceptable temperature standards at serving time are as follows: Meats, Entrees, Casseroles >140 degrees but preferably 160-175 F. Cold salad/s desserts <41 degrees but preferably 35 degrees F. Cold Beverages: Milk, Juice <41 degrees but preferably 35 degrees F. Cakes, Pastries 60 degrees F. ...7. Food items that do not meet acceptable levels and cannot be corrected in time for meal service will not be served and an appropriate substitution is to be made." 3.1-21(i)(3)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p>			

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	<p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review, and interview, the facility failed to develop and implement appropriate plans of action to address food storage, preparation and distribution under sanitary conditions concerns identified during the Annual Recertification and State Licensure survey.</p> <p>Findings include:</p> <p>During an interview on 7/21/14 at 5:30 p.m., the Administration Consultant, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Medical Records Staff, Social Service Director, Activity Director and the MDS coordinator were queried regarding QAA (Quality Assurance and Assessment) and the identified concern of the annual</p>	F000520	F-520The plan of correction for this deficiency will be to develop and implement a plan of action to address food storage, sanitary conditions and distribution of food. The facility dates all food in the refrigerator and checks for outdated food daily.The facility reassign cleaning duties to ensure debris does not build up on floor or walls.All received food items will be dated upon arrival by the person receiving the weekly stock.All Cooking utensils will be stored properly.To ensure this deficient practice does not recur, The dietary manager or their designee will be responsible for physically checking and documenting the results of:1. Dating and storing refrigerated items2. Storing clean and ready to use utensils.3. Dating of newly received food items.4. Cleanliness of floors and walls.5.	08/20/2014

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 07/21/2014
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	<p>survey as follows:</p> <ol style="list-style-type: none"> 1. No dates on multiple food items stored in the three door stainless steel refrigerator. 2. The walls and floor throughout the kitchen and storage areas had food, debris and grime on them. 3. Ready to use clean cooking utensils not stored properly. 4. The dry storage rooms contained the following cans, bottles and jars with no received date: 8 bottles, 4 jars of mayonnaise, 2 jars of salsa, 2 bottles of vegetable oil, 17 jars of broth, 2 jars of peanut butter, 9 cream of chicken soup, 4 cream of mushroom soup and 78 gallon cans of prepared food items. 5. During meal service observation on 7/18/14 at 11:33 a.m. Cook #2 checked the temperature of the food to be served at lunch. The following was observed: Pureed ham salad on a croissant was 71 degrees Fahrenheit. Macaroni salad was 73 degrees Fahrenheit. Vegetable soup was 172 degrees Fahrenheit. Chicken patty sandwich was 135 degrees Fahrenheit. 		<p>Taking Temperatures on all food items served. Record of all of the above items will be checked on a daily basis and documented as completed or done. The results of these audits will be given to the administrator for review and updates at our QA. All Families/Residents /Staff will be made aware of the QA process and how to notify the QA team of a concern that needs addressed. All dietary staff will be inserviced on the process. All staff will be inserviced on how to report a concern to QA. A memo explaining how to report concerns to QA will be placed in the front lobby for Families/Staff/Residents. The inservice will take place by the 20th of August. The administrator will do random checks 2 times weekly to help correct actions.</p>	

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	<p>High calorie pudding was 54 degrees Fahrenheit. Cottage cheese was 47.5 degrees Fahrenheit. Chocolate milk was 40.8 degrees Fahrenheit. Honey thickened mild was 50 degrees Fahrenheit. Ranch dressing was 45.7 degrees Fahrenheit. French dressing was 49.4 degrees Fahrenheit. Shredded cheese was 49.5 degrees Fahrenheit. Diced eggs was 47.3 degrees Fahrenheit.</p> <p>During an interview on 7/21/14 at 5:30 p.m., the Assistant Director of Nursing (ADON) and the Dietary Manager indicated there was no action plan in place in the QAA program regarding the kitchen, storage or temperatures. The Dietary Manager indicated she agreed there was a QAA concern related to the kitchen and there was no auditing in place at this time.</p> <p>3.1-52(b)(2)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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