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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155522 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/15/2016 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY PARKVIEW HEALTH AND LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2300 PARKVIEW LN<br>ELWOOD, IN 46036 |
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| F 0000<br><br>Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 8, 9,10,11,14,15, 2016</p> <p>Facility number: 000372<br/>Provider number: 155522<br/>AIM number: 100289060</p> <p>Census bed type:<br/>SNF/NF: 68<br/>Residential: 9<br/>Total: 77</p> <p>Census payor type:<br/>Medicare: 11<br/>Medicaid: 50<br/>Other: 16<br/>Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on March 17, 2016.</p> | F 0000        | Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Health & Living 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 Health & Living. The facility requests the following plan of correction be considered for PAPER COMPLIANCE REVIEW. |                      |

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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| F 0247<br>SS=D<br>Bldg. 00 | <p>483.15(e)(2)<br/>RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to notify residents prior to the arrival of a new roommate for 2 of 5 residents reviewed for notification of change (Residents # 71 &amp; #3).</p> <p>Findings include:</p> <p>1. During an interview with Resident #3, beginning on 3/8/16 at 2:10 p.m., she indicated she had received a new roommate within the last month. She further indicated she had been notified just a few minutes prior to her new roommate's arrival to the facility.</p> <p>Review of Resident #3's clinical record began on 3/8/16 at 2:33 p.m. There was no indication in the clinical record of Resident #3 having been notified of receiving a new roommate.</p> <p>2. During an interview with Resident #71, beginning on 3/9/16 at 9:20 a.m., she indicated she had received a new roommate within the last month. She</p> | F 0247        | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: SOCIAL SERVICE WILL ENSURE THAT NOTIFICATION AND DOCUMENTATION IS DONE PRIOR TO A ROOMMATE CHANGE BY UTILIZING A FORM "ROOMMATE NOTIFICATION", THIS FORM IS SIGNED BY THE RESIDENT, OR RESPONSIBLE PARTY IF RESIDENT IS NOT INTERVIEWABLE, AS ACKNOWLEDGMENT OF THE NOTIFICATION. SOCIAL SERVICE WILL ALSO DOCUMENT THE NOTIFICATION IN THE ELECTRONIC MEDICAL RECORD. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: SOCIAL SERVICE WILL ENSURE THAT NOTIFICATION AND DOCUMENTATION IS DONE PRIOR TO A ROOMMATE CHANGE BY UTILIZING A FORM "ROOMMATE</p> | 04/08/2016           |

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|  | <p>further indicated she had not been notified until her new roommate had arrived at the facility with her family.</p> <p>Review of Resident 71's clinical record began on 3/8/16 at 2:40 p.m. There was no indication in the clinical record of Resident #71 having been notified of receiving a new roommate.</p> <p>During an interview on 3/15/16 at 10:57 a.m., the Social Services Director indicated it was not facility practice to document when a roommate change was made, only when a resident changed rooms. She indicated she probably had a conversation with the residents about a new roommate coming, but could not determine when the conversation had taken place or what the resident's response was.</p> <p>3.1-3(v)(2)</p> |   | <p>NOTIFICATION", THIS FORM IS SIGNED BY THE RESIDENT, OR RESPONSIBLE PARTY IF RESIDENT IS NOT INTERVIEWABLE, AS ACKNOWLEDGMENT OF THE NOTIFICATION. SOCIAL SERVICE WILL ALSO DOCUMENT THE NOTIFICATION IN THE ELECTRONIC MEDICAL RECORD. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: SOCIAL SERVICE WILL ENSURE THAT NOTIFICATION AND DOCUMENTATION IS DONE PRIOR TO A ROOMMATE CHANGE BY UTILIZING A FORM "ROOMMATE NOTIFICATION", THIS FORM IS SIGNED BY THE RESIDENT, OR RESPONSIBLE PARTY IF RESIDENT IS NOT INTERVIEWABLE, AS ACKNOWLEDGMENT OF THE NOTIFICATION. SOCIAL SERVICE WILL ALSO DOCUMENT THE NOTIFICATION IN THE ELECTRONIC MEDICAL RECORD. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ADMINISTRATOR WILL CONDUCT AUDITS MONTHLY (UNTIL 100% FOR 90 DAYS)FOR COMPLIANCE AND</p> |                      |   |

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| F 0248<br>SS=D<br>Bldg. 00   | <p>483.15(f)(1)<br/>ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in 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 develop an individualized activities program for cognitively impaired residents for 1 of 3 residents reviewed for activities (Resident #33).</p> <p>Findings include:</p> <p>On 3/9/16 at 9:53 a.m. Resident #33 was seated in her wheelchair during the "Move and Groove" activity. Her head was down and her eyes were closed.</p> <p>On 3/10/16 at 9:05 a.m. Resident #33 was asleep in bed.</p> <p>On 3/10/16 at 10:12 a.m. Resident #33 was sitting in her wheelchair in the hallway near the lobby. A church/devotional service was taking place in the dining room.</p> <p>On 3/10/16 at 2:21 p.m., Resident #33</p> |   |  | F 0248  | <p>REVIEW FINDINGS DURING MONTHLY QI/QA MEETING</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The activity program for Res #33 was updated to reflect her passive attendance/dozing at activities of interest. Resident #33 activity assessment and preferences are current and she will continue to be invited, assisted to and from these activities of interest. If resident falls asleep for more than 50% of the activity her attendance will recorded as passive and if she does not meet the active participation attendance criteria each week, she will have 1:1 activity done. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The activity program for other residents that are both active &amp; passive during activity events will have their activity programs updated to reflect passive attendance at activities of</p> |   | 04/08/2016           |

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|                    | <p>was sitting in her wheelchair outside of the nurse's station.</p> <p>On 3/11/16 at 10:10 a.m., Resident #33 was sitting in her room in her wheelchair. The resident was looking down. Her T.V. was turned off.</p> <p>On 3/11/16 at 11:15 a.m., Resident #33 was in her wheelchair in the hallway near the lobby. A small sensory group was meeting near the aviary.</p> <p>On 3/11/16 at 2:15 p.m. Resident #33 was in her wheelchair in her room. A musician was playing a concert in the dining room for the monthly resident's birthday party.</p> <p>On 3/14/16 at 8:43 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off.</p> <p>On 3/14/16 at 10:16 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off.</p> <p>On 3/14/16 at 10:40 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off. A church/devotional service was taking place in the dining room.</p> <p>On 3/14/16 at 11:11 a.m., Resident #33</p> |               | <p>interest. . If a resident falls asleep for more than 50% of the activity the attendance will be recorded as passive and if that resident does not meet the active participation attendance criteria each week, that resident will have 1:1 activity done. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The active participation criteria for each resident is to attend at least two out of room events per week. The activity staff was educated by the Activity Director on the change to record attendance as active or passive, and the 1:1 to be done if the criteria is not met. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Activity Director will review the activity attendance logs for active &amp; passive participation. The Activity Director will determine if the attendance criteria was met and if the 1:1 was done when needed. The Activity Director will record findings and review monthly/quarterly during QI/QA meeting.</p> |                      |

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|                    | <p>was sitting in her wheelchair in the common area near the aviary with four other residents. Activity Assistant #5 was approaching the three other residents with a chirping bird decoration, asking if they knew what the sound was. Resident #33's head was down. Activity Assistant #5 stated "Did you fall asleep on me again?", indicating Resident #33, and resumed the activity with the other residents. Resident #33 remained with her head down.</p> <p>On 3/14/16 at 11:28 a.m. Resident #33 remained sitting in her wheelchair, chin to chest, in the common area near the aviary. Facility staff were propelling the other residents from the area, indicating it was nearing lunchtime.</p> <p>On 3/15/16 at 10:27 a.m., Resident #33 was sitting in her wheelchair in her room with her eyes closed. Her T.V. was turned off.</p> <p>Review of Resident #33's clinical record began on 3/9/16 at 8:39 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, and altered mental status.</p> <p>Resident #33 had a 2/12/16 significant change Minimum Data Set (MDS) assessment, which indicated she was</p> |               |   |                      |

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|                    | <p>severely cognitively impaired and required extensive assistance for mobility and locomotion.</p> <p>Resident #33 had a current careplan problem of activities. It indicated she preferred attending bingo, church, entertainments, parties, cooking club, arts and crafts. The careplan goal was for Resident #33 to attend one activity daily. Interventions included the following: "arrange transportation, assure the activity is compatible with the resident's capabilities, remind resident and escort/assist her to the activity."</p> <p>Review of an Activities Progress Note, dated 2/12/16, indicated Resident #33 attended activities of interest, enjoyed art therapy, move and groove, food related activities, entertainment, bingo, games, and manicures.</p> <p>Review of an activities log for March, 2016 indicated the following:</p> <p>Refused all activities on 3/4 and 3/6.<br/>Refused all activities on 3/8.<br/>Refused all activities on 3/11.<br/>Refused all activities on 3/12.<br/>Refused all activities on 3/13.</p> <p>Review of an "INDIVIDUAL RESIDENT DAILY ACTIVITIES</p> |               |   |                      |

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|                    | <p>MARCH 2016" indicated the following:</p> <p>"Visits with others": 3/5/16.<br/>"Halls": 3/6, 3/6, 3/10, 3/11.<br/>Ate lunch in activity room 3/7/16.</p> <p>During an interview, on 3/14/16 at 1:17 p.m., Activity Assistants #5 and #9 indicated Resident #33 attended activities depending on her mood. They further indicated she didn't really attend group activities as much as she used to and they had been trying to get her to go to some of the smaller sensory groups. They further indicated Resident #33 didn't respond much at group activities, whether it was large or small groups. They indicated she used to like "Move and Groove, but generally just sat there during the activity when they had her come to it. Activity Assistant #9 indicated Resident #33 enjoyed wandering the hallways in her wheelchair and visiting with other residents. When questioned further, she indicated the resident cannot propel her own wheelchair purposefully and usually sits in the hallway outside of the nurse's station.</p> <p>On 3/14/16 at 2:22 p.m., the Social Services Director/Life Enrichment Director indicated Resident #33 usually attended smaller groups and larger</p> |               |   |                      |

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| F 0280<br>SS=D<br>Bldg. 00 | <p>groups. She also indicated the resident did well meeting one-on-one with staff and that they were working on improving the program.</p> <p>3.1-33(a)</p> <p>483.20(d)(3), 483.10(k)(2)<br/>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to update activities careplans to reflect changes in the needs of cognitively impaired residents for 1 of 3 residents reviewed for activities (Resident #33).</p> <p>Findings include:</p> | F 0280        | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The activity care plan for Res #33 was updated to reflect her passive attendance/dozing at activities of interest. Resident #33 activity assessment and preferences are current and she will continue to be invited, assisted to and from</p> | 04/08/2016           |

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|                    | <p>On 3/9/16 at 9:53 a.m. Resident #33 was seated in her wheelchair during the "Move and Groove" activity. Her head was down and her eyes were closed.</p> <p>On 3/10/16 at 9:05 a.m. Resident #33 was asleep in bed.</p> <p>On 3/10/16 at 10:12 a.m. Resident #33 was sitting in her wheelchair in the hallway near the lobby. A church/devotional service was taking place in the dining room.</p> <p>On 3/10/16 at 2:21 p.m., Resident #33 was sitting in her wheelchair outside of the nurse's station.</p> <p>On 3/11/16 at 10:10 a.m., Resident #33 was sitting in her room in her wheelchair. The resident was looking down. Her T.V. was turned off.</p> <p>On 3/11/16 at 11:15 a.m., Resident #33 was in her wheelchair in the hallway near the lobby. A small sensory group was meeting near the aviary.</p> <p>On 3/11/16 at 2:15 p.m. Resident #33 was in her wheelchair in her room. A musician was playing a concert in the dining room for the monthly resident's birthday party.</p> |               | <p>these activities of interest. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The activity care plan for other residents that are both active &amp; passive during activity events will be updated to reflect passive attendance at activities of interest. . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Activity Director will update the care plans for each resident with passive/dozing participation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Activity Director will review the activity attendance logs for active &amp; passive participation. The Activity Director will update the care plans as needed when the resident's participation status changes. The Activity Director will record findings and review monthly/quarterly during QI/QA meeting.</p> |                      |

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|                    | <p>On 3/14/16 at 8:43 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off.</p> <p>On 3/14/16 at 10:16 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off.</p> <p>On 3/14/16 at 10:40 a.m., Resident #33 was sitting in her wheelchair in her room, chin to chest. Her T.V. was off. A church/devotional service was taking place in the dining room.</p> <p>On 3/14/16 at 11:11 a.m., Resident #33 was sitting in her wheelchair in the common area near the aviary with four other residents. Activity Assistant #5 was approaching the three other residents with a chirping bird decoration, asking if they knew what the sound was. Resident #33's head was down. Activity Assistant #5 stated "Did you fall asleep on me again?", indicating Resident #33, and resumed the activity with the other residents. Resident #33 remained with her head down.</p> <p>On 3/14/16 at 11:28 a.m. Resident #33 remained sitting in her wheelchair, chin to chest, in the common area near the aviary. Facility staff were propelling the other residents from the area, indicating it was nearing lunchtime.</p> |               |   |                      |

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|                    | <p>On 3/15/16 at 10:27 a.m., Resident #33 was sitting in her wheelchair in her room with her eyes closed. Her T.V. was turned off.</p> <p>Review of Resident #33's clinical record began on 3/9/16 at 8:39 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, and altered mental status.</p> <p>Resident #33 had a 2/12/16 significant change Minimum Data Set (MDS) assessment, which indicated she was severely cognitively impaired and required extensive assistance for mobility and locomotion.</p> <p>Resident #33 had a current careplan problem of activities. She preferred attending bingo, church, entertainments, parties, cooking club, arts and crafts. The careplan goal was for Resident #33 to attend one activity daily. Interventions included the following: "arrange transportation, assure the activity is compatible with the resident's capabilities, remind resident and escort/assist her to the activity."</p> <p>Review of an Activities Progress Note, dated 2/12/16, indicated Resident #33 attended activities of interest, enjoyed art</p> |               |   |                      |

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|                    | <p>therapy, move and groove, food related activities, entertainment, bingo, games, and manicures.</p> <p>Review of an activities log for March 2016 indicated the following:<br/>Refused all activities on 3/4 and 3/6.<br/>Refused all activities on 3/8.<br/>Refused all activities on 3/11.<br/>Refused all activities on 3/12.<br/>Refused all activities on 3/13.</p> <p>Review of an "INDIVIDUAL RESIDENT DAILY ACTIVITIES MARCH 2016" indicated the following:<br/><br/>"Visits with others": 3/5/16.<br/>"Halls": 3/6, 3/6, 3/10, 3/11.<br/>Ate lunch in activity room 3/7/16.</p> <p>During an interview, on 3/14/16 at 1:17 p.m., Activity Assistants #5 and #9 indicated Resident #33 attended activities depending on her mood. They further indicated she didn't really attend group activities as much as she used to and they had been trying to get her to go to some of the smaller sensory groups. They further indicated Resident #33 didn't respond much at group activities, whether it was large or small groups. They indicated she used to like "Move and Groove, but generally just sat there during the activity when they had her</p> |               |   |                      |

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| F 0282<br>SS=D<br>Bldg. 00 | <p>come to it. Activity Assistant #9 indicated Resident #33 enjoyed wandering the hallways in her wheelchair and visiting with other residents. When questioned further, she indicated the resident cannot propel her own wheelchair purposefully and usually sits in the hallway outside of the nurse's station.</p> <p>On 3/14/16 at 2:22 p.m., the Social Services Director/Life Enrichment Director indicated Resident #33 usually attended smaller groups and larger groups. She also indicated the resident did well meeting one-on-one with staff and that they are working on improving the program.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br/>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed for 1 of 1 resident reviewed for dialysis (Resident #36) and 2 of 5 residents reviewed for unnecessary medications (Residents #82, and 45).</p> | F 0282        | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Res #36 & #82-A review of the daily weights for Res #36 from June 2015 to March 2016, and Res #82 from September 2015 to March 2016, | 04/08/2016           |

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|  | <p>Findings include:</p> <p>1. Resident #36's clinical record was reviewed on 3/14/16 at 9:13 a.m. Resident #36's current diagnoses included, but were not limited to, end stage renal disease (ESRD) and heart failure.</p> <p>Resident #36 had a 2/24/16 care plan problem of potential fluid deficit related to fluid restriction for renal failure, congestive heart failure and edema. Interventions included: "Monitor weight per protocol/as ordered and notify the registered dietician and physician of weight loss or gain greater than five pounds."</p> <p>Resident #36 had a current physician's order, dated 2/10/15, that indicated she needed to be weighed daily and the physician needed to be notified of a weight gain greater than five pounds.</p> <p>Review of the "Treatment Record" and "Weights and Vitals Summary", provided by the D.O.N. on 3/14/16 at 11:40 a.m., indicated weights were not entered on the following dates: 6/3/15, 6/9/15, 6/28/15, 8/31/15, 9/5/15, 9/13/15, 9/14/15, 10/3/15, 10/4/15, 11/21/15, 11/22/15, 12/5/15, 12/6/15, 12/28/15, 1/3/16, 1/16/15, 1/17/16, 2/18/16, 3/11/16, and</p> |   | <p>did not show a significant weight change despite the missing daily weights. Daily weights will be completed and documented per physician order. Res #36-Resident will have fistula monitored and documented per policy. Res #36-Resident will have fluids received with medications documented on the Fluid Restriction LogRes #45-Will receive insulin per physician order How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Daily weights will be completed and documented per physician order. Other resident(s) with fistulas will be monitored and documented per policy Other resident(s) with fluid restriction will have fluids received with medications documented on the Fluid Restriction LogOther resident receiving insulin will receive insulin per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be educated on the "Daily Weight Protocol" by DON/ADON. The assignment for daily weights will be distributed each morning to the appropriate staff. The daily weights are to be completed and recorded into the electronic medical record before breakfast each morning. The facility policy titled "Care of</p> |   |  |   |  |

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|                    | <p>3/12/16.</p> <p>During an interview with the D.O.N. on 3/14/16 at 1:13 p.m., she indicated the "Treatment Record" and the "Weights and Vitals Summary" was where daily weights would be recorded.</p> <p>Resident #36 had a current physician's order, dated 2/10/15, that indicated the fistula to her right upper arm needed to be monitored every shift.</p> <p>Review of Resident #36's clinical record indicated there was no documentation of the monitoring of the fistula.</p> <p>During an interview with the D.O.N. on 3/14/16 at 1:13 p.m., she indicated the fistula was not being monitored.</p> <p>Resident #36 had a current physician's order, dated 7/8/15, that indicated she was on a 1500 milliliter fluid restriction and nursing staff was to document the amount of fluids taken each shift with medications.</p> <p>Review of the medication administration record, provided by the D.O.N. on 3/14/16 at 11:40 a.m., indicated fluid intake with medications was not documented for 31 days in January, 29 days in February, and 14 of 14 days in</p> |               | <p>residents who receive hemodialysis outside of facility" will be educated to appropriate staff by Director of Nursing, or designee. The policy includes daily documentation of fistula patency. Nursing Staff will be educated on documenting fluid intake with medications on the Fluid Restriction Log by the DON/ADON. Nursing Staff will be educated on following physician order for administration of insulin by the Director of Nursing, or designee. The RN was disciplined for not following policy. The RN reviewed the policy for following physician orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Director of Nursing, or designee, will run the "Weights &amp; Vitals Summary Report" on each business day, verify documentation of daily weights, and address any non-compliance with the appropriate staff. DON, or designee, will review findings monthly/quarterly at QI /QA meeting. The Director of Nursing, or designee, will review the TARS for each resident with a fistula for compliance with documentation of fistula patency and note findings on the Dialysis Audit Tool on each business day and address any non-compliance with the appropriate staff. DON, or</p> |                      |

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|  | <p>March 2016.</p> <p>During an interview with the D.O.N. on 3/14/16 at 1:13 p.m., she indicated the medication administration record was where fluid intake with medications would be recorded.</p> <p>2. A review of the medical record for Resident #82 began on 3/10/2016 at 9:06 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Hypertension, Congestive Heart Failure, Major Depressive Disorder, and Unspecified Dementia with Behavioral Disturbance.</p> <p>Resident #82 had a current physician order to be weighed daily related to Congestive Heart Failure, dated 9/4/2015.</p> <p>The "Weights and Vitals Summary" and "Treatment Record" for Resident #82 was provided by the Director of Nursing on 3/14/2016 at 11:40 a.m. It indicated no weights had been recorded for one day in September 2015, three days in October 2015, two days in November 2015, two days in December 2015, one day in January 2016, and three days in February 2016.</p> <p>During an interview with LPN #20, on 3/10/2016 at 10:33 a.m., she indicated weights for each resident were</p> |   | <p>designee, will review findings for documentation monthly/quarterly at QI /QA meeting. The Director of Nursing, or designee, will review the Fluid Restriction Log on each business day for each resident with a fluid restriction order for compliance with documentation of fluid intakes and address any non-compliance with the appropriate staff. DON, or designee, will review findings for documentation monthly/quarterly at QI /QA meeting. The Director of Nursing, or designee, will conduct random insulin administration observations three times a week for compliance with following physician order. DON, or designee, will review findings monthly/quarterly at QI /QA meeting.</p> |                      |   |

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|                    | <p>documented in the computer under the "weights" tab or on the treatment record.</p> <p>3. A review of the medical record for Resident #45 began on 3/9/2016 at 2:00 p.m. and indicated his diagnoses included, but were not limited to, Chronic Kidney Disease, Congestive Heart Failure, and Diabetes.</p> <p>Resident #45 had a current physician order for Humalog (insulin) that indicated to "inject 16 units sub Q (subcutaneous) before meals for DM (diabetes mellitus)."</p> <p>During an interview with RN #7 on 3/9/2016 at 10:58 a.m., she indicated that she never gave insulin to a resident before they ate a meal. She indicated that was how she was trained and that was how she had always practiced.</p> <p>During an interview with RN #7 on 3/10/2016 at 11:17 a.m., she indicated that Resident #45 had not received his insulin and she would administer it after he returned from lunch.</p> <p>During an interview with RN #7 on 3/14/2016 at 1:03 p.m., she indicated she was aware that the physician order for Resident #45 indicated his insulin should be given before lunch.</p> |               |   |                      |

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| F 0309<br>SS=D<br>Bldg. 00 | <p>On 3/10/2016 at 12:45 p.m., Resident #45 was observed returning to his room from lunch.</p> <p>During a medication administration observation on 3/10/2016 at 12:51 p.m. RN #7 administered Humalog (insulin) to Resident #45.</p> <p>3.1-35(g)(2)</p> <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure assessments were completed and preventative measures put in place to prevent a wound on the heel from worsening for 1 of 3 residents reviewed for wounds (Resident #62).</p> <p>B. Based on interview and record review, the facility failed to pre and post dialysis assessments was done for 1 of 1 residents reviewed for dialysis (Resident</p> | F 0309        | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Res #62-Resident continues to have weekly skin assessments completed and preventative measures in place For resident #36, Pre and post dialysis assessments will be completed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: On | 04/08/2016           |

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|  | <p>#36).</p> <p>Findings include:</p> <p>A. During an observation of a wound dressing change on 3/10/16 at 2:30 p.m., a wound to Resident #62's right heel was half dollar size with a pink center and pencil eraser sized black areas at the top and right edges. The skin surrounding the wound was pale, dry, and flaky.</p> <p>During an observation of a wound dressing change on 3/11/16 at 1:00 p.m., a wound to Resident #62's left heel was rectangular shaped and covered the back of the heel. The wound was black in color. The skin surrounding the wound was pale, dry, and flaky.</p> <p>Resident #62's clinical record was reviewed on 3/10/16 at 9:25 a.m. and indicated the resident had been admitted on 2/4/16. Resident #62's current diagnoses included, but were not limited to, gastrointestinal hemorrhage, diabetes, chronic ischemic heart disease, heart failure, and mild intellectual disabilities.</p> <p>Resident #62 had a current, 3/3/16, significant change, Minimum Data Set (MDS) assessment which indicated she was moderately cognitively impaired and needed extensive assistance for mobility.</p> |   | <p>February 23, 2016 a skin assessment was completed on all in-house residents, and offloading devices/preventative measures were put in place, if not already in place. Other residents continue to have weekly skin assessments completed and preventative measures in place Other residents receiving dialysis services will have pre and post dialysis assessments done What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing Staff were educated on March 9, 2016 by DON regarding protocol for completing weekly skin assessments. Nursing Staff will be educated on Skin Assessment and implementation of preventative/offloading devices by Wound Certified Nurse. The policy titled "Care of Resident who receives Hemodialysis (outside of facility)" will be reviewed with nursing staff. The policy includes a communication and assessment form for completing pre and post assessments. This form will be sent to the dialysis provider with each resident on dialysis days and received back to facility upon return. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Director of Nursing, or designee will continue to conduct</p> |                      |   |

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|                    | <p>Review of a document titled, "Nursing Admission Assessment", dated 2/4/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., indicated Resident #62 had no skin alterations to her heels on admission to the facility.</p> <p>Review of two documents titled, "Braden Scale for Predicting Pressure Sore Risk", dated 2/5/16 and 3/4/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., included the following: "...Sensory Perception...Ability to respond meaningfully to pressure-related discomfort...No impairment...Has no sensory deficit which would limit ability to feel or voice pain or discomfort...."</p> <p>Review of "Progress Notes", dated from 2/5/16 through 2/13/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., had no indications of skin alterations to Resident #62's heels.</p> <p>Review of a "New wound Alert Note", dated 2/19/16 at 8:00 a.m., provided by the D.O.N on 3/15/16 at 8:47 a.m., indicated Resident #62's left heel had a hematoma over most of her left heel with a skin tear in the top layer of the skin over the hematoma.</p> <p>Review of a "New wound Alert Note",</p> |               | <p>weekly audits of skin assessments. Director of Nursing, or designee will conduct audits for implementation of appropriate preventative devices. Findings of audits will be reviewed during monthly/quarterly QI/QA meeting. The Director of Nursing, or designee, will complete audits twice a week for compliance with the "Care of Resident who receives Hemodialysis (outside of facility)" policy and document audits on "Dialysis Form Audits". Findings of audits will be reviewed during monthly/quarterly QI/QA meeting.</p> |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY PARKVIEW HEALTH AND LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2300 PARKVIEW LN<br>ELWOOD, IN 46036 |
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|                    | <p>dated 2/19/16 at 11:00 a.m., provided by the D.O.N on 3/15/16 at 8:47 a.m., included the following: "...Describe Wound: Left heel wound had a ruptured blister, and was draining dark red fluid. Used forceps and scissors to remove the devitalized tissue, and this revealed wound base that is dark red and had deep purple hue in the center of the wound..."</p> <p>Review of a document titled, "Wound Nurse Assessment", dated 2/19/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., included the following: "...Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue...Concerned that this likely was a sDTI [suspected Deep Tissue Injury], and has opened. With the purple hue in the wound base, I am concerned that this wound will evolve into a stage III or greater wound. History of recent GI bleed, which likely produced hypoxia to distal limbs, and resultantly this wound... Have recommended aggressive treatment suggestion to MD...."</p> <p>Review of Resident #62's physician's</p> |               |   |                      |

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|                    | <p>orders indicated the following orders were initiated on 2/19/16: "Resident #62 to see podiatrist for offloading shoe to left heel, consult with dietician for pressure ulcer to left heel and pressure reducing boot to left heel at all times."</p> <p>Review of a "New wound Alert Note", dated 3/5/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., included the following: "...Location of Wound: OUTER ASPECT OF RIGHT HEEL Describe Wound: AREA DK. [dark] PURPLE IN COLOR, WITH SLIT TO RIGHT SIDE OF AREA...."</p> <p>Review of Resident #62's physician's orders indicated a pressure reducing boot to the right heel at all times was started on 3/5/16.</p> <p>Review of a document titled, "Wound Nurse Assessment", dated 3/8/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., included the following: "Site 49) Right heel...Wound bed is pink in appearance with islands of red tissue. Small eschar [dry, dark scab] area noted at 12 o'clock et [and] one at 3 o'clock...."</p> <p>Review of a document titled, "Wound Nurse Assessment", dated 3/8/16, provided by the D.O.N. on 3/15/16 at 8:47 a.m., included the following: "Site</p> |               |   |                      |

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|                    | <p>50) Left heel... Wound presents with the deep purple hue et is starting to separate from wound edges at top of wound... awaiting physician approval to send to wound clinic et other various recommendations..."</p> <p>During an interview with Consultant #1 on 3/10/16 at 3:15 p.m., she indicated that the wound to Resident #62's left heel began as a SDTI (status deep tissue injury). She also indicated that the wound to her right heel probably started as a blister. She also indicated the injury probably happened at the hospital, but wouldn't show up for maybe seven days.</p> <p>During an interview with Consultant #1 on 3/11/16 at 1:06 p.m., she indicated Resident #62 had neuropathy to both of her feet and therefore could not feel much pain and that is why there was dry, flaky skin surrounding the wounds on her heels.</p> <p>During an interview with Resident #62 on 3/11/16 at 1:11 p.m., she indicated that she could feel her feet only a little.</p> <p>During an interview with the D.O.N. on 3/15/16 at 10:49 a.m., she indicated that part of a skin assessment was assessing heels for discoloration. She also indicated that she needed to re-educate</p> |               |   |                      |

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|                    | <p>staff that residents with neuropathy or diabetes would likely have little to no feeling in their feet and would therefore need to be indicated as having impaired sensory perception on the "Braden Scale for Predicting Pressure Sore Risk".</p> <p>No further documentation or information was provided before exit on 3/15/16.</p> <p>B. Resident #36's clinical record was reviewed on 3/14/16 at 9:13 a.m. Resident #36's current diagnoses included, but were not limited to, end stage renal disease (ESRD) and heart failure.</p> <p>Review of the dialysis communication sheets, dated from 2/1/16 through 3/9/16, provided by the D.O.N. on 3/11/16 at 1:30 p.m., indicated a post-dialysis assessment was not documented on the following dates: 2/3/16, 2/26/16, 2/29/16, and 3/4/16. There was no documentation of assessments during dialysis provided.</p> <p>During an interview with RN #3 on 3/11/16 at 12:42 p.m., she indicated the facility had just changed Dialysis communication sheets because they were having issues with the old ones. She also indicated that no documentation was being communicated from the Dialysis center and the communication sheets</p> |               |   |                      |

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| F 0323<br>SS=D<br>Bldg. 00   | <p>were not being filled out upon return from facility.</p> <p>During an interview with the D.O.N. on 3/11/16 at 12:52 p.m., she indicated the facility had not been communicating with the dialysis facility. She also indicated that the resident was not being assessed prior to and upon returning from dialysis as was expected.</p> <p>3.1-37(a)</p> <p>483.25(h)<br/>FREE OF ACCIDENT<br/>HAZARDS/SUPERVISION/DEVICES<br/>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 medications were securely stored for 1 of 5 medication carts. This practice had the potential to affect 15 of 68 residents residing in the facility whose medications were stored in the north 200 hall medication cart.</p> <p>Findings include:</p> <p>On 3/11/16 at 10:12 a.m., the north 200 hall medication cart was observed near</p> | F 0323  | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The medication cart will be locked at all times unless attended by appropriate personnel. No medications are to be preset for any reason. Upon discharge, medications are to be pulled from the medication cart and disposed of per policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be</p> | 04/08/2016  |  |   |  |

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|  | <p>the nurse's station, unlocked and unattended. QMA # 3 was observed walking away from the cart toward another medication cart at the other end of the hallway.</p> <p>An observation of the medication cart, beginning at 10:19 a.m. with QMA #3, indicated the cart contained, but was not limited to, the following medications:</p> <p>Nuedexta (a mood stabilizer), Trilipal 300 mg (anti-seizure), Risperdal 1 mg (anti-psychotic), Effexor XR 150 mg (anti-depressant), acyclovir 400mg (anti-viral), ceftriaxone 1 gm (injectable antibiotic), lidocaine 1% vial, heparin 50 units/5mL 10mL flush (blood thinner), nitro-bid tablets, atropine (nerve relaxant) eye drops, and Advair 100/50 (inhaled steroid).</p> <p>A large plastic baggie, containing 8 small envelopes, was observed in the third drawer of the cart. Each unlabeled envelope contained 13 pills and capsules.</p> <p>During the observation, QMA #3 indicated the envelopes contained medications belonging to Resident #10, who had been discharged to her home from the facility. QMA #3 indicated she had set the medications up in the envelopes because Resident #10's pills</p> |   | <p>taken: The medication carts will be locked at all times unless attended by appropriate personnel. No medications are to be preset for any reason. Upon discharge, medications are to be pulled from the medication cart and disposed of per policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The QMA was disciplined for not following the policy to keep medication carts locked at all times unless attended, presetting medications and not pulling medications upon discharge. The QMA reviewed the medication storage policy, the medication administration policy, and the medication disposal policy. Personnel who are responsible for the medication carts will be re-educated on the medication storage policy, the medication administration policy and the medication disposal policy by the DON/ADON. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Director of Nursing, or designee, will conduct random audits 3 times a week for compliance with medication storage policy, medication administration policy and medication disposal policy. The audits will be documented on a form and the findings reviewed</p> |                      |   |

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| F 0431<br>SS=E   | <p>came in bottles and took up a lot of time during medication pass. She further indicated she had been aware she should not have removed the medications from the containers.</p> <p>During an interview with the Administrator on 3/11/16 at 10:32 a.m., during the observation of the medication cart, she indicated the medication cart was to be kept locked and medications were not to be set up prior to administration.</p> <p>Review of Resident #10's clinical record on 3/11/16 at 11:13 a.m., indicated she had been discharged from the facility on 3/8/16.</p> <p>Review of a policy, titled "Storage of Medications", dated January 2007, and received from the Administrator on 3/11/16 at 12:32 p.m., indicated the following:</p> <p>"...B. ...Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access...."</p> <p>3.1-45(a)(1)</p> <p>483.60(b), (d), (e)<br/>DRUG RECORDS, LABEL/STORE DRUGS</p> |   | monthly/quarterly during the QI/QA meeting.   |                      |   |

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| Bldg. 00   | <p><b>&amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were disposed of following a resident's discharge from the facility (Resident #10). This practice had the potential to affect 1 of 36 closed records</p> | F 0431  | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Any medications belonging to Res #10 were disposed of on March 11, 2016 and documented in the | 04/08/2016           |   |

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|  | <p>reviewed.</p> <p>Findings include:</p> <p>On 3/11/16 at 10:12 a.m., the north 200 hall medication cart was observed near the nurse's station, unlocked and unattended. QMA # 3 was observed walking from the cart toward another medication cart at the other end of the hallway.</p> <p>An observation of the medication cart, beginning at 10:19 a.m. with QMA #3, indicated the following:</p> <p>A large plastic baggie, containing 8 small envelopes, was observed in the third drawer of the cart. Each unlabeled envelope contained 13 pills and capsules.</p> <p>During the observation, QMA #3 indicated the envelopes contained medications belonging to Resident #10, who had been discharged to her home from the facility. QMA #3 indicated she had set the medications up in the envelopes because Resident #10's pills came in bottles and took up a lot of time during medication pass. She further indicated she had been aware she should not have removed the medications from the containers. She indicated the medications should have been sent with</p> |   | <p>medical record. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Upon discharge, medications are to be pulled from the medication cart and disposed of per policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The QMA was disciplined for not following the medication disposal policy. The QMA reviewed the medication disposal policy. Personnel who are responsible for the medication carts will be re-educated on the medication disposal policy by the DON/ADON. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Director of Nursing, or designee, will conduct random audits 3 times a week for compliance with medication disposal policy. The audits will be documented on a form and the findings reviewed monthly/quarterly during the QI/QA meeting.</p> |                      |   |

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| R 0000<br><br>Bldg. 00 | <p>Resident #10 at her discharge from the facility.</p> <p>Review of Resident #10's clinical record on 3/11/16 at 11:13 a.m., indicated she had been discharged from the facility on 3/8/16. Review of a policy, titled "Medication Destruction", dated January 2007 and received from the Administrator on 3/11/16 at 12:32 p.m., indicated the following: "...Discontinued medications and medications left in the facility after a resident's discharge if not qualifying for the return to the pharmacy for credit, are destroyed...."</p> <p>3.1-25(j)<br/>3.1-25(k)<br/>3.1-25(l)</p> <p>This was a visit for a State Residential Licensure Survey</p> <p>Residential Census: 9</p> <p>Sample: 7</p> <p>Community Parkview Health and Living</p> | R 0000        | Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Health & Living 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 Health & Living. The |                      |

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|  | was found to be in compliance with 410 IAC 16.2-5 in regard to State Residential Licensure Survey.                     |   | facility requests the following plan of correction be considered for PAPER COMPLIANCE REVIEW.                   |                      |   |