STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITERIVER BLVD MUNCIE, IN 47303

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 15, 16, 17, 18, 19, and 22, 2012 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Survey team: Ginger McNamee, RN-TC Betty Retherford, RN Karen Lewis, RN Census bed type: SNF: 3 SNF/NF: 71 Total: 74 Census payor type: Medicare: 8 Medicaid: 58 Other: 8 Total: 74 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 24, 2012 by Bev Faulkner, RN	F0000	Please find the attached plan of correction for a visit from your office on October 22, 2012, Survey Event ID# UBKQ11, in accordance with state law. We respectfully request that your office will accept this plan as our facility's compliance and that you will consider a desk review in view there were no tags that were deemed to be actual harm or immediate jeopardy. If you have any additional questions, please contact me at (765)289-3341. Thank you in advance or your immediate attention in this matter.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review and interview, the facility failed to ensure resident call lights were responded to in a manner to maintain the resident's dignity for 2 of 3 residents interviewed and 1 of 3 families interviewed regarding timely response to call lights. (Resident #18, 54, and 96) Findings include: 1.) The clinical record for Resident #18 was reviewed on 10/22/12 at 10:05 a.m. Diagnoses for Resident #18 included, but were not limited to, bipolar disorder, traumatic brain injury, and hypertension. An annual Minimum Data Set (MDS) assessment, dated 8/18/12, indicated Resident #18 was cognitively intact. During an interview on 10/16/12 at 8:50 a.m., Resident #18 indicated he uses his call light when needed. He indicated it can take at least 30-40	F0241	F241 Residents #18, 54 and 96 were interviewed by Social Services staff to determine if there were any outstanding concerns with call light response. Administrative staff have met with the Resident Council regarding concerns that had been brought forward regarding call lights not being answered timely. A one time interview of alert and oriented residents has been conducted to ensure concerns have been brought forward to staff. Staff have been re-educated on call light response expectations. It is the responsibility of any staff member to answer call lights. 50% of resident population will be interviewed weekly for compliance of their call lights being answered timely 5 times a week for 4 weeks, twice weekly for 8 weeks, and then 50% randomly monthly for 6 months. Resident Council will be asked at its regular monthly meeting and if special meetings are held to determine if the current actions	11/19/2012

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	minutes to be answered at least 2 times a day. He indicated they sometimes turn it off and say they will be back, then not return. 2.) The clinical record for Resident #54 was reviewed on 10/22/12 at 9:55 a.m. Diagnoses for Resident #54 included, but were not limited to, diabetes mellitus type 2, hypertension, and history of cerebrovascular accident. An annual MDS, dated 8/6/12, indicated Resident #54 had mild cognitive impairment. During an interview on 10/15/12 at 2:50 p.m., Resident #54 indicated he had to wait over 15 minutes for his call light to be answered at least 2 times a week. He stated he had once waited for an hour. He indicated he had a clock in his room that he used to time the wait. 3.) The clinical record for Resident #96 was reviewed on 10/18/12 at 1:20 p.m. Diagnoses for the resident included, but were not limited to, fractured left shoulder, coronary artery disease,		being taken by staff have met their needs for call light response. Any issues identified will be immediately addressed, including disciplinary action, up to and including termination. . The ADM/designee will review the results of the interviews weekly and address any concerns noted. Any concerns that the Resident Council addresses will be written on a Resident Concern Form and provided to the Administrator and remedy, action or resolution will be addressed at the next regularly scheduled Resident Council meeting. Results of the interviews will be forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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	chronic pain, and prostate cancer. During an interview on 10/15/12 at 3:30 p.m., Resident #96's wife indicated she uses the call light to obtain staff for Resident #96 when she visits. She indicated over the past weekend she had to wait 30-40 minutes on at least 2 occasions and the resident was incontinent. She indicated she also had to wait over 15 minutes several times in the previous week. She has a watch and there is a clock in the room. She indicated she went to the DoN that morning to complain about the long call light waits. During an interview on 10/15/12 at 3:35 p.m., the resident's daughter also indicated she had waited over 15 minutes for the resident's call light to be answered on multiple occasions. 4.) The current undated procedure for "Call Light and Intercom Systems" was provided by the RN Consultant on 10/22/12 at 1:00 p.m. The procedure indicated residents must have a way of communicating with the health care staff at all times and a call light system can be used to alert staff of a resident needing help. The procedure indicated all requests for assistance should be answered			

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	promptly. 3.1-3(t)			

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F0244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.			
	Based on record review and interview, the facility failed to ensure resident council grievances were responded to and acted upon in a timely manner in regards to concerns expressed regarding long call light waits for 3 of 6 resident council meetings reviewed and for 3 of 4 residents reviewed who complained of insufficient staff. (Resident #'s 54, 18, 40) Findings include: During a review of Resident Council minutes on 10/17/12 at 1:00 p.m., the following was noted: 5/2/12-"Nursing: Call lights are still taking too long to answer..." 6/2/12- "Old Business: ...Nursing: Call lights not answered timely, concern form filled out...." New business: ...Nursing: Call lights are still taking too long to answer...."	F0244	F244 Residents #18, 54 and 96 were interviewed by Social Services staff to determine if there were any outstanding concerns with call light response. Administrative staff have met with the Resident Council regarding concerns that had been brought forward regarding call lights not being answered timely. A one time interview of alert and oriented residents has been conducted to ensure concerns have been brought forward to staff. A special Resident Council meeting has been conducted to address resident concerns with call light response. Staff have been re-educated on call light response expectations, as well as responding to Resident Council meeting concerns. It is the responsibility of any staff member to answer call lights. 50% of resident population will be interviewed weekly for compliance of their call lights being answered timely 5 times a week for 4 weeks, twice weekly	11/19/2012

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	7/11/12- "Old Business: [name of Resident #17 and Resident #45] both state their call lights are not working and it takes too long for assistance to get to them. Work orders and concern forms filled out." No information was documented related to the facility's response to the concern form filled out on 6/2/12 or if any improvement was noted. 8/1/12-Old business concerns of call lights were not addressed. No response was provided to the residents. During an interview with the Social Services Director on 10/18/12 at 2:45 p.m., additional information was requested related to the follow-up to the Resident Council concerns noted above from 5/2/12 through the present. During an interview with the Social Services Director on 10/18/12 at 4:00 p.m., she indicated she was not aware of the call light concern expressed by the residents during the meeting on 5/2/12. She indicated she did receive the concern form filled out on 6/2/12 and a staff inservice on timely call light response was completed. She indicated the activity staff present at the council meetings		for 8 weeks, and then 50% randomly monthly for 6 months. Resident Council will be asked at its regular monthly meeting and if special meetings are held to determine if the current actions being taken by staff have met their needs for call light response. Any issues identified will be immediately addressed, including disciplinary action, up to and including termination. . The ADM/designee will review the results of the interviews weekly and address any concerns noted. Any concerns that the Resident Council addresses will be written on a Resident Concern Form and provided to the Administrator and remedy, action or resolution will be addressed at the next regularly scheduled Resident Council meeting. Results of the interviews will be forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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	were to relate this information back to the council. She indicated she received the concern form for the 7/11/12 meeting and had the maintenance staff check the call lights. She indicated one of them needed repaired, but the other one was working correctly when checked. During the resident interviews noted below, the timely answering of call lights still continued to be a problem: During an interview on 10/15/12 at 2:50 p.m., Resident #54 (who intermittently attends Resident Council meetings) indicated he had to wait over 15 minutes for his call light to be answered at least 2 times a week. He stated he had once waited for an hour. He indicated he had a clock in his room that he used to time the wait. During an interview on 10/16/12 at 8:50 a.m., Resident #18 (who intermittently attends Resident Council meetings) indicated he uses his call light when needed. He indicated it can take at least 30-40 minutes to be answered at least 2 times a day. He indicated they sometimes turn it off and say they will be back, then not return.			

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	During an interview on 10/17/12 at 1:00 p.m., Resident #40 (the Resident Council President) indicated "sometimes they don't get back to me with any info.... Call lights not being answered has been a problem for awhile." He indicated they sometimes come in and turn it off and don't come back. "They are busy." The undated 1/10 revised "Resident Council" policy and procedure" was provided by the RN Consultant on 10/22/12 at 1:00 p.m. The policy indicated the residents have the right to organize and participate in resident groups in the center. The procedure indicated "...2. Propose to the Council that the Social Worker be present at the initial meeting to communicate their value of the Resident Council....3. Report requests to the Administrator and/or responsible department, who will subsequently prepare a response to any request for the Council. Respond in writing to written requests of the Resident Council within time frame indicated in the "Grievance" Procedure by completing the "Center Follow-Up" section of the Resident Council Request (Copy form). 4. Report concerns/grievances to the Administrator and/or responsible department, who will subsequently prepare a response to any			

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	concerns/grievances from the Council. Respond in writing to written concerns/grievances of the Resident Council within time frame indicated in the "Grievance" Procedure by completing the Resident Concern Report...." 3.1-3(l)			

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F0246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview, the facility failed to ensure a resident's wheelchair was equipped with foot pedals that did not hinder the resident from being seated in front of the dining room table in order to feed herself easily for 1 of 3 residents reviewed of the 19 who met the criteria for assistance with activities of daily living. (Resident #37) Findings include: 1.) The clinical record for Resident #37 was reviewed on 10/19/12 at 8:50 a.m. Diagnoses for Resident #37 included, but were not limited to, schizophrenia, diabetes mellitus, spinal stenosis, and dysphagia. A quarterly Minimum Data Set assessment, dated 8/30/12, indicated Resident #37 was severely cognitively impaired and required the assistance	F0246	F 246 Resident #37 leg rests were adjusted allowing her to sit directly in front of the table. A one time audit of current resident population has been completed to ensure residents have the appropriate equipment in place. Staff have been re-educated to seat each resident directly in front of the dining room table during meal times. It is the responsibility of the staff to ensure residents are seated appropriately at the dining room table for meals. The dining manager on duty will be responsible to monitor compliance through observation of resident meal time seating daily times 14 days, weekly across shifts times 8 weeks, and then as needed with dining room supervision monthly. Any issues identified will be immediately addressed, including disciplinary action up to and including termination. . Results of the observations will be reviewed by the	11/19/2012

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	of the staff for all activities of daily living. During an observation on 10/15/12 at 12:25 p.m., Resident #37 was up in her wheelchair in the dining room. The resident was sitting at an angle next to the table. She was leaning on her right arm in the wheelchair and could barely reach the items on the table with her left hand. At 12:40 p.m. a staff member put her closer to the table, but she was still at an angle that made it more difficult for her to feed herself. The chair was unable to be placed directly in front of the table because the footrests were extended out and they hit the center table support. During an observation on 10/16/12 at 8:20 a.m., Resident #37 was up in her wheelchair in the dining room. The leg rests were still elevated and she could not sit directly in front of the table. During an observation on 10/19/12 at 12:40 p.m., Resident #37 was up in her wheelchair in the dining room. The leg rests were still elevated and she could not sit directly in front of the table. During an interview with the DoN and		ADM/designee weekly, and forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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	RN Consultant on 10/19/12 at 1 p.m., additional information was requested related to Resident #37 not being able to sit in front of the table as noted above. During an interview on 10/19/12 at 1:20 p.m., the DoN indicated she had talked with the staff and the foot pedals on the resident's wheelchair were too long and couldn't be lowered without hitting the floor. She indicated she would have that problem corrected. 3.1-3(v)(1) 3.1-19(w)(5)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident was provided psychological services in a timely manner for 1 of 10 residents reviewed for psychological services. (Resident #17) Findings include: The clinical record for Resident #17 was reviewed on 10/17/12 at 3:15 p.m. Diagnoses for Resident #17 included, but were not limited to, depression, schizoaffective disorder, history of panic attacks, and insomnia. A recapitulation of physician's orders, dated 10/11/12, indicated the resident had orders for the following behavior related and/or mood altering medications: Depakote 3000 milligrams (mgs) daily for schizophrenia (order last adjusted on 9/5/12)	F0250	F250 Social Services reviewed record of Resident #17 and referral was made to the psychological services, which was to include the review of the tearfulness. A one time audit has been completed to ensure no other referral or physician order was missed. Staff have been re-educated on completing follow up review to psychological services progress notes within the next business day. It is the responsibility of the Social Services staff to ensure psychological services progress notes are reviewed for any potential recommendation. SS staff will be responsible to bring forward the progress notes following psychological services daily times 14 days, weekly for 8 weeks, and then monthly. Communication, verbal or written will take place between Social Services and Doctor or Nurse Practitioner weekly after each visit pertaining to any Psychosocial recommendations or changes. Any issues identified will be immediately addressed,	11/19/2012

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	Depo-Provera 150 mg intramuscularly (IM) every 4 weeks due to history of abuse (original order date 2/17/11) Risperidone 3 mgs twice daily and 1.5 mg daily at 2 p.m. for schizoaffective disorder. (order last adjusted on 2/2/12) Cymbalta 90 mg daily for depression (original order date 11/8/11) Risperdal Consta 50 mg IM every two weeks for schizophrenia (original order date 2/17/11) A "Psychotherapy Assessment," dated 7/25/12, indicated the resident had been evaluated by a licensed social worker. The form indicated the resident would benefit from psychotherapy sessions two times weekly with a goal of increased socialization and program participation and stabilization of depressed mood. The clinical record lacked any information related to the resident attending psychotherapy sessions following this evaluation. A physician's order written for Resident #17, dated 9/27/12, indicated "Please ask psych		including disciplinary action, up to and including termination. The Administrator/designee will review results of the Social Services review. Results of the Social Service reviews will be forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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	[psychological services] to see regarding tearfulness." The clinical record lacked any information related to a referral for psychological services having been made related to the above noted physician's order. During an interview with the DoN (Director of Nursing) and RN Consultant on 10/18/12 at 12:55 p.m., additional information was requested related to the lack of follow-up of the "Psychotherapy Assessment," dated 7/25/12, and the physician order, dated 9/27/12. A "Referral for Services" form, dated 10/18/12, was provided by the DoN on 10/18/12 at 3:15 p.m. The form indicated a referral for psychological services had been made to Vericare (a provider of mental health services). During an interview on 10/22/12 at 11:10 a.m., the DoN indicated no referral for care had been made prior to the request for information on 10/18/12. The current 4/2000, policy and procedure for "Mental Health Services - Referral to" was provided by the RN Consultant on 10/22/12 at 1:00 p.m. The policy indicated the facility strives			

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	to ensure the resident who displays behavioral symptoms or psychosocial adjustment difficultly receives appropriate treatment and services to treat the assessed problem. The procedure indicated "1. Maintain a list of local mental health providers including physicians, mental health agencies, and licensed therapists who provide such care....3. Identify actual or potential mental or psychosocial adjustment difficulties. 4. Work with the Nursing department to obtain mental health services. 5. Request a physician's order for psychiatric or psychological assessment as needed. 6. Assist the psychiatrist or psychologist as needed and follow up on any referrals made. 7. Assist the residents in arranging transportation to and from mental health providers, as needed...." 3.1-34(a)			

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F0282 SS=D	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 record review and interview, the nursing staff failed to ensure a laboratory test was obtained timely as ordered by the physician for 1 of 10 residents reviewed for unnecessary medications. (Resident #62) Findings include: The clinical record for Resident #62 was reviewed on 10/18/12 at 9:41 a.m. Diagnoses for Resident #62 included, but were not limited to, depression, hypertension, dementia with delusions and behavioral disturbances, and anxiety. An August 2012 pharmacist recommendation to monitor a fasting blood glucose was accepted by the physician. A fasting blood glucose laboratory test was ordered at that time. The clinical record lacked any results for a fasting blood glucose laboratory	F0282	F 282 Resident #62's attending physician was notified, and an order was obtained for the lab monitoring. A one time audit of pharmacy recommendations for the last 3 months has been completed to ensure recommendations were completed as approved by the attending physician. Licensed staff have been re-educated on completing pharmacy recommendations timely. It is the responsibility of the Licensed supervisory staff to ensure recommendations are acted on once the attending physician has approved the recommendation. The DON/designee will be responsible to review the monthly pharmacy recommendations, and direct staff in completing the recommendation upon approval. Compliance will be reviewed monthly through reconciliation of recommendations. Any issues identified will be immediately addressed, up to and including disciplinary action, up to and including termination.	11/19/2012

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	test ordered by the physician in August 2012, for Resident #62. During an interview with the Director of Nursing on 10/19/12 at 2:36 p.m., additional information was requested regarding the lack of an August fasting blood glucose laboratory result. During an interview with the Director of Nursing on 10/22/12 at 11:10 a.m., she indicated the fasting blood glucose laboratory test had not been obtained. Review of the current facility policy, dated 7/09, titled "Pharmacy Services," provided by the RN Consultant on 10/22/12 at 1:00 p.m., included, but was not limited to, the following: "...Procedure 1. Contract services with an approved pharmacy vendor.... ...3. Take action on monthly reports of drug regimen reviews when irregularities are reported by the consultant...." 3.1-35(g)(2)		The Administrator/Designee will be responsible to review the results of audits monthly for 6 months. . Results of the Pharmacy Recommendation reviews will be forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	A.) Based on record review and interview, the facility failed to ensure a resident was not given medications with a potential for a drug interaction without approval from the physician (Resident #17) and failed to ensure bowel monitoring was completed so interventions to relieve constipation could be provided (Resident #39) for 2 of 10 residents reviewed for unnecessary medications. B.) Based on record review, observation, and interview, the facility failed to ensure a resident's dressing was changed in a timely manner for 1 of 1 resident observed who had an outdated dressing observed on his lower leg. (Resident #31) Findings include: A.1.) The clinical record for Resident #17 was reviewed on 10/17/12 at 3:15 p.m. Diagnoses for Resident #17 included,	F0309	F 309 The Nurse Practitioner reviewed resident #17 drug interaction sheet during the survey. Resident #39 bowel function was reviewed with no issues noted. Resident #31 dressing was changed. A one time audit of current resident population has been conducted to ensure potential drug interaction notices have been reviewed, bowel monitoring has been completed, and dressing changes are current. Nursing staff have been re-educated on bowel monitoring and bowel protocol. Licensed staff will be re-educated on pharmacy drug interaction sheets, and providing dressing changes in a timely manner It is the responsibility of Licensed Supervisory Nurses to review the potential drug interaction notices, complete bowel monitoring review daily, and complete dressing changes as per physician order. UM/designee will monitor compliance with bowel monitoring	11/19/2012

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	but were not limited to, chronic obstructive pulmonary disease (COPD), muscle spasms, and schizoaffective disorder. The clinical record indicated Resident #17 received Cyclobenzaprine (a muscle relaxer) 10 milligrams (mg) four times daily for muscle spasms. The original date of this order was 2/17/11. The medication administration record (MAR) indicated this medication was given at 8:30 a.m. and 12:30, 4:30, and 8:30 p.m. A Nurse Practitioner's progress note, dated 10/11/12, indicated the resident was seen for an exacerbation of his COPD and new orders were received. New orders for Resident #17, dated 10/11/12, which included, but were not limited to, Duoneb (a medication given to help improve respirations) nebulizer treatment three times daily for 10 days then every 4 hours as needed for congestion. A fax from the pharmacy, dated 10/11/12 at 10:49 p.m., related to the new order for the Duoneb medication indicated the following: "...Drug dispensed: Iprat-Albut 0.5-3 (2.5) mg [generic for Duoneb]		through care tracker bowel reports 5 x weekly. UM/designee will monitor compliance with timely dressing changes through 3 random observations daily for 14 days, 3x weekly for 8 weeks, and then weekly for 12 weeks. UM/designee will monitor drug interaction sheet compliance daily for 14 days, 3x weekly for 8 weeks, and then weekly for 12 weeks Any issues identified will be immediately addressed, including disciplinary action, up to and including termination. . The Administrator/Designee will be responsible to review the results of audits monthly for 6 months. . Results of the Pharmacy Recommendation reviews will be forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee.	

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	Interacts with: Cyclobenzaprine 10 mg ... Severity Level: 3 Patient Management: The concurrent use of inhaled sympathomimetics and tricyclic compounds or the use of these agents within 14 days of each other should be approached with extreme caution." The form lacked any information related to possible side effects for which to monitor if the medications continued to be given together on a daily basis. A handwritten notation on the form indicated the form was faxed to the physician on 10/12/12. The clinical record lacked any response from the physician related to the pharmacy warning. The MAR indicated Duoneb nebulizer treatment was started on 10/11/12 at 6:00 p.m. and was then given 3 times daily as ordered except for 4 occasions when the resident refused the treatment during that time period. The MAR indicated the Cyclobenzaprine medication continued to be given four times daily during this time period.			

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	During an interview on 10/18/12 at 9:50 a.m., RN #2 (working on Resident #17's unit) indicated she had not seen the pharmacy warning noted above and did not know what a "Severity Level: 3" meant. During an interview on 10/18/12 at 9:55 a.m., LPN #1 (working on Resident #17's unit) indicated she had not seen the pharmacy warning noted above and did not know what a "Severity Level: 3" meant. LPN #1 took the pharmacy warning from the clinical record and took it to the Nurse Practitioner who was reviewing charts on the unit at that time. The Nurse Practitioner indicated a "Severity Level 3" was minor in nature and it was alright to continue giving the medications. The Nurse Practitioner wrote "Ok to continue Monitor for tachycardia and nausea" and signed and dated the note. During an interview with the DoN on 10/18/12 at 12:55 p.m., additional information was requested related to nursing staff giving the medications together without approval from the physician and/or nurse practitioner following receipt of the pharmacy warning noted above prior to the notation from the Nurse Practitioner's			

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	visit on 10/18/12 at 9:55 a.m. The facility failed to provide any additional information as of exit on 10/22/12. A.2.) The clinical record for Resident #39 was reviewed on 10/18/12 at 1:46 p.m. Diagnoses for Resident #39 included, but were not limited to, depression, hypertension, schizophrenia, and anxiety. Quarterly Nursing Data Collection and Assessments, dated 6/30/12 and 9/28/12, indicated Resident #39 was incontinent of bowel and totally dependent for toileting. A Bowel Data Collection and Assessment, dated 9/28/12, indicated Resident #39 was always incontinent and unable to feel the urge sensation for a bowel movement. A health care plan problem, dated 11/9/10, indicated Resident #39 was incontinent of bowel. One of the goals for this problem indicated the resident would have a bowel movement at least every three days. Approaches for this problem was included "Monitor bowel elimination using CareTracker," and "Provide medication as ordered to aid in			

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	elimination as ordered". Resident #39 had an order for Milk of Magnesia (laxative) 30 milliliters by mouth every day as needed for constipation. The original date of this order was 9/27/12. The bowel movement records for September and October 2012 indicated the resident did not have a bowel movement for the following time period: September 30 - October 5, 2012. A code of "1" (which indicated no bowel movement) was documented for each shift on those dates. A time period of 6 days without a recorded bowel movement. The nursing notes and medication administration records (MAR) lacked any information related to Milk of Magnesia having been given, or facility bowel protocol having been followed during this time period. During an interview with the Director of Nursing (DoN) on 10/22/12 at 11:10 a.m., additional information was requested related to the lack of bowel monitoring and administration of physician ordered interventions having been completed for the time			

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	period noted above. The facility failed to provide any additional information related to the lack of bowel monitoring noted above as of exit on 10/22/12. Review of the current facility policy, dated 1/09, titled "Constipation," provided by the RN Consultant on 10/22/12 at 1:00 p.m., included, but was not limited to, the following: "Policy Extendicare Health Services, Inc. (EHSI) recognizes constipation is the most frequent complaint of older people regarding bowel function. Actual constipation is defined as three or more days without defecation. Constipation is a state in which a resident experiences a change in bowel habits characterized by a decrease in frequency and/or passage of hard, dry stools.... ...Management of constipation is be accomplished by reduction or elimination of contributing factors , when able.			

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	Standard bowel care to relieve constipation (in absence of a bowel obstruction) with a provider order may include the following: Milk of Magnesia 30 cc PO every third day without BM...." B.1.) The clinical record for Resident #31 was 10/22/12 at 11:12 a.m. Diagnoses for Resident #31 included, but were not limited to, skin fibrosis, scar conditions, vitiligo, and dermatitis. A health care plan problem, dated 916/12, indicated Resident #31 had a wound on his right shin. One of the goals for this problem was for the wound to be healed by the next careplan review. One of the approaches for this problem included "Provide treatment per physician order". An order, dated 9/19/12, indicated to discontinue current Santyl (debriding agent) orders. Start cleanse right shin wound with normal saline, apply Santyl topically, cover with gauze dressing, and secure with coverall daily.			

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	During an interview with Resident # 31 on 10/16/12, the right shin dressing was observed to be dated 10/14/12. During an interview with Resident #31 on 10/22/12 at 3:14 p.m., resident had the dressing the nurse removed from his right shin during treatment today in a glove. The dressing was dated 10/14/12. During an interview with the Director of Nursing and RN #3 on 10/22/12 at 3:20 p.m., she indicated the date of the dressing she removed today from Resident #39's right shin was dated 10/14/12. During an interview with RN #3 on 10/22/12 at 3:30 p.m., she indicated the wound was not measured today. She also indicated the wound looked better and was scabbing. Review of the October Treatment Administration Record (TAR) indicated the dressing to the right shin had been initialed as having been completed on 10/15/12, 10/16/12, and 10/21/12. The other dates were either blank or indicated the resident was on leave of absence. During an interview with Director of			

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	Nursing on 10/22/12 at 3:40 p.m., she indicated she was made aware of the concerns with the dressing change and she would be addressing the concerns with the nursing staff. 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure a resident was given assistance as needed in order to feed herself easily for 1 of 3 residents reviewed of the 19 who met the criteria for assistance with activities of daily living. (Resident #37) Findings include: 1.) The clinical record for Resident #37 was reviewed on 10/19/12 at 8:50 a.m. Diagnoses for Resident #37 included, but were not limited to, schizophrenia, diabetes mellitus, spinal stenosis, and dysphagia (difficulty swallowing). A quarterly Minimum Data Set assessment, dated 8/30/12, indicated Resident #37 was severely cognitively impaired and required the assistance of the staff for all activities of daily living. A health care plan problem, dated	F0312	F 312 Resident #37 leg rests were adjusted allowing her to sit directly in front of the table. A one time audit of current resident population has been completed to ensure residents have the appropriate equipment in place. Staff have been re-educated to seat each resident directly in front of the dining room table during meal times. It is the responsibility of the staff to ensure residents are seated appropriately at the dining room table for meals. The dining manager on duty will be responsible to monitor compliance through observation of resident meal time seating daily times 14 days, weekly across shifts times 8 weeks, and then as needed with dining room supervision monthly. Any issues identified will be immediately addressed, up to and including disciplinary action, up to and including termination. . . Results of the observations will	11/19/2012

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303	

(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
	10/10/12, indicated Resident #37 was a nutritional risk. Interventions for this problem included, but were not limited to, providing assistance with setting up her tray and assisting as needed. During an observation on 10/15/12 at 12:25 p.m., Resident #37 was up in her wheelchair in the dining room. She had been given a pureed diet. There were no spoons in the food. The spoons were still wrapped in the napkin. Her pudding type dessert still had the plastic cover on it. Her ice cream was still covered. There was no straw in her carton of milk. She did not receive any cueing or assistance until 12:40 p.m. At that time, a staff member made the silverware available to the resident. She then started to feed herself. The dessert remained covered at this time. During an interview with the DoN and RN Consultant on 10/19/12 at 1 p.m., additional information was requested related to Resident #37's tray not being prepared for her timely on 10/15/12 as noted above. During an interview on 10/19/12 at 1:20 p.m., the DoN indicated staff should properly prepare the resident's		be reviewed by the ADM/designee weekly, and forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee	

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	tray and that the resident should be cued and assisted with meals as necessary. 2.) Review of the current, undated, "PREPARING FOR MEAL TIME AND ASSISTING THE PERSON TO EAT," procedure provided by the RN Consultant on 10/22/12 at 1:00 p.m., included, but was not limited to, the following: "...Position the person for eating.... ...Help the person to eat as necessary.... ...Depending on the situation, you may also need to help the person with opening milk cartons or removing silverware from its wrapper, buttering bread, or cutting up meat...." 3.1-38(a)(2)(D)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITERIVER BLVD MUNCIE, IN 47303

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain walls, floors, toilets and closet doors for 10 of 29 resident rooms observed. This had the potential to 60 residents of the 74 residents in the facility. Findings include: The environmental tour was conducted with the Administrator on 10/22/12 from 1:05 p.m. to 1:39 p.m. The following observations were made: Room 108 had knicks in the bathroom door and the wall to the right of the bathroom door had missing plaster. Room 110 had missing drywall to the right of the bathroom door and the corner of the doorway was patched and not painted. Room 304, the interior side of the bathroom door was gouged and missing wood. The plaster on the wall around the exterior side of the bathroom door was rough.	F0465	F465 The Rooms 108, 110, 304, 306, 310, 210, 217, 226, 228, 230, 231, and 232 were placed on maintenance work orders and the repairs for each room were completed. A one time audit of resident bathrooms and rooms have been inspected for needed repairs and those repairs have been scheduled for completion. Staff have been re-educated on the completion of work orders when there are maintenance or broken items that need repair. It is the Maintenance Director's responsibility to ensure center areas have been reviewed for maintenance needs, and repairs are implemented as necessary. Rounds to review the center for repair needs will be completed by the Maintenance/Administrator/designee weekly to ensure the resident rooms are in good repair. Any issues identified will be immediately addressed, up to and including disciplinary action, up to and including termination. Results of the observations will be reviewed by the	11/19/2012

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303	

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	Room 306, the closet doors were off the tracks, the bathroom door was knicked and the plaster was rough around the exterior bathroom door frame. Room 310, the interior side of the bathroom door had a hole in it. Paint was missing on the wall at the end of the bed. Room 210, the interior side of the bathroom door had 2 holes in it. The wall below the lower right corner of the window had a hole in it. There was a quarter to half inch gap between the bathroom flooring and the room tile. The wall plaster to the left of the bathroom door was rough. There was caulking missing around the base of the toilet. Room 217, the wall on the right side of the bathroom door was chipped and gouged. There was a quarter to half inch gap between the bathroom flooring and the tile room floor. There was a sheet wrapped around the base of the toilet. During an interview with Resident #22 on 10/22/12 at 1:25 p.m., the resident indicated the bathroom stool leaked. There was caulk missing around the base of the toilet. The closet door was off of the track.		ADM/designee weekly, and forwarded to the Quality Performance Improvement Committee for review and further corrective action as determined necessary by the QPI Committee	

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	Room 226 had a quarter to half inch gap between the room floor tile and the bathroom flooring. The wall to the left of the bathroom door had rough cracked plaster. Room 228 had the closet doors off of the tracks. The exterior hinge side of the door to the room was gouged and rough. Room 230 had both closet doors off of the tracks and the wall to the left of the bathroom door was missing plaster. Room 231, the closet door was off the track and the interior side of the bathroom door and the door frame was knicked. Room 232, the door to the room and the bathroom door was gouged. 3.1-19(f)			