STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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F0000				
	This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey-substandard quality of care. This visit included the Investigation of Complaint IN00101921. Complaint IN00101921-Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 30 and 31, February 1, 2, and 3, 2012 Facility number: 000539 Provider number: 155746 AIM number: 100267280 Survey team: Kelly Sizemore, RN-TC Sheila Sizemore, RN (January 30, 31, and February 2 and 3, 2012) Regina Sanders, RN (January 30, 31, and February 1 and 2, 2012) Marcia Mital, RN Census bed type: NF: 1 SNF/NF: 38 Residential: 17	F0000		

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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	Total: 56 Census payor type: Medicare: 6 Medicaid: 21 Other: 29 Total: 56 Sample: 10 Supplemental sample: 4 Residential sample: 5 Residential supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 2/9/12 by Jennie Bartelt, RN.			

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	155746		02/03/2012

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report allegations of abuse to ISDH (Indiana State Department of Health) in a timely manner, thoroughly	F0225	F225 Report abuse immediately to the Administrator Correction CN A's 19, 20, 21, and 22 were educated on the abuse policy and appropriate notification procedure	02/24/2012

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	investigate allegations of abuse, and protect residents from the potential for abuse, for 1 of 5 residents reviewed for abuse allegations in a sample of 10 (Resident #14) and 1 of 2 residents reviewed for abuse in a supplemental sample of 4 (Resident #29). Findings include: 1. Review of a "Facility Incident Reporting Form" indicated the incident date was 07/17/11 at approximately 1:00 p.m. The form indicated, "...(CNA #19) reported to DoN (Director of Nursing) on 07/19/11 that on 07/17/11 CNA (CNA #20) was assisting resident (Resident #29) to toilet and she heard (CNA #20) say to (Resident #29) if you don't help me I am going to leave you on the toilet until 9 pm..." This allegation was reported to the DoN and the investigation was initiated two days after the incident occurred. The form indicated the DoN reported the allegation to the ISDH on 07/20/11, which was 3 days after the incident had occurred. The investigation lacked documentation to indicate the facility's Administrator had been notified of the allegation. CNA #20's employee time card indicated CNA #20 continued to work on 07/17/11		on 2-17-12. Residents 29 and 14 experienced no harm from cited deficiencies as the original investigations of alleged abuse had confirmed that abuse had not occurred. Identification: The deficient practice has the potential to affect all residents, so plant-wide training was and will be conducted as described below. System Change: The Abuse Prohibition Policy was reviewed and revised to state that abuse will be reported immediately to the administrator, that the administrator will report allegations of abuse to the ISDH, Adult Protective Services, and the ombudsman within 24 hours, and that investigations will consist of components which will guarantee thoroughness. The social services director or charge nurse will chart that the administrator has been notified of the allegation of abuse. The entire staff, including contracted employees, will be trained on the definition of abuse, on the entire abuse prevention policy, and specifically will be trained that suspected abuse must be reported immediately to the administrator. Emphasis will be placed on resident protection resulting from immediate notification. The staff and contracted employees will be trained that according to the Elder Justice Act, crimes must be reported immediately to the administrator and to the pertinent police authorities. Training will	

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	from 11 a.m. to 2:30 p.m., 2:30 p.m. to 6:30 p.m., 6:45 p.m. to 9 p.m., 07/18/11 from 2:30 p.m. to 5:45 p.m. and 6:15 p.m. to 9 p.m., after the allegation had been made. During an interview on 01/31/12 at 2:05 p.m., the Administrator indicated CNA #19 should have reported the allegation immediately. He indicated after the allegation was reported on 07/19/11, CNA #20 did not work on 7/19/11. During an interview on 02/01/12 at 10:05 a.m., the Administrator indicated he could not say when he was notified. He indicated the DoN immediately notified him as she was doing the investigation. He indicated the DoN showed him the investigation before she sent it to the ISDH. 2. A, "Facility Incident Reporting Form", indicated the incident date was 11/06/11 at 6:30 a.m.. The form indicated, "Early Sunday a.m. (11/06/11) (CNA #21) was working on the day shift--usually she works nights. (CNA #21) went into (Resident #14's) room to assist her...Later in the morning (Resident #14) told another CNA, (CNA #22) that (CNA #21) is mean to her..." The form indicated the Administrator started the investigation on 11/07/11, which was 24 hours after the		occur by 2-24-12. The administrator, and in his absence the Director of Nursing, will report allegations of abuse within 24 hours to the Indiana State Department of Health, Adult Protective Services, and to the ombudsman and as necessary to other authorities. The administrator will conduct thorough investigations and will retain investigation materials. Since many resident behaviors may also be abuse, the behavior management book has been supplemented with a reference to abuse definitions and abuse reporting requirements. All employees were trained on this by 2-24-12. Monitor: Allegations will be reviewed in daily inter-disciplinary stand-up meetings, watching especially for timeliness of reporting to the administrator and timeliness of the administrator reporting to the ISDH. The Director of Nursing will review each allegation's investigation for thoroughness and timely reporting. Abuse allegations will be reviewed by the Social Services Consultant bi-monthly. Abuse allegations will be discussed at the Monthly Quality Improvement meeting for trends and prevention and for recommendations of further or revised training. Date of Compliance 2-24-12	

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	allegation occurred. A behavior monitoring record, dated 11/6/12 at 7 a.m. to 9 a.m., indicated, "Resident was telling other staff members that I was mean to her...Told CNA that she does not want me in her room to help her ever again." The behavior monitoring record was signed by CNA #21 and CNA #22. A handwritten note, dated 11/07/11 (one day after allegation), signed by CNA #21, indicated, "Just a heads up. Had some issues come up yesterday with (Resident #14)...(CNA #22) pushes her out to breakfast and the entire time she (Resident #14) told her how mean I was and that she never wants me in her room again. Found out this morning from (CNA #20) that she told her that I yelled at her...Now when I went in to take her to the bathroom tonight she was ok with me until she asked me my name...She rolled her eyes and didn't say another word to me...She rang again later on and this time (CNA #22)...went down. (Resident #14) asked (CNA #22) her name. She answered oh good I'm glad it's not that (CNA #21) again. I don't want her in here... " The fax cover form, indicated the allegation of abuse was reported to the			

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	ISDH by the Administrator on 11/08/11, which was 48 hours after the allegation was made. During an interview on 02/02/12 at 9:50 a.m., the Social Service Director indicated the allegation on occurred on 11/06/1 at 6:30 a.m. She indicated the CNA's wrote it in the behavior book. She indicated possibly the reason they were not notified of the allegation on 11/06/12 was because it was a Sunday. During an interview on 02/02/12 at 9:50 a.m., the Administrator indicated CNA #21 had, " told on herself " on the behavior sheet. He indicated CNA #21 should have reported the allegation immediately. The facility's undated abuse policy, received as current by the Administrator on 01/31/12, titled, "Primary Policy Abuse Prohibition", indicated, " ...Notify the Social Services Director, D.O.N. or the administrator immediately of any alleged violation...Indiana State Department of Health will be notified by fax within 24 hours of allegation... " 3.1-28(c) 3.1-28(d)			

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F0226 SS=F	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	A. Based on record review and interview, the facility failed to develop and implement an abuse policy related to notifying the Administrator of any abuse allegations, reporting allegations to ISDH (Indiana State Department of Health), and protection of residents from the potential for abuse, for 1 of 5 residents reviewed for abuse allegations in a sample of 10 (Resident #14) and 1 of 2 residents reviewed for abuse in a supplemental sample of 4 (Resident #29). B. Based on record review and interview, the facility failed to train employees on their abuse policy prior to working on the floor with residents for 4 of 4 employees hired within the last four months (RN #2, CNA #3, CNA #4, RN#5) and 13 of 13 contracted therapists (Therapist #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17 and #18). This deficient practice had the potential to affect 39 of 39 residents who reside in the facility. Findings include: A. The facility's undated abuse policy, received as current by the Administrator	F0226	F226 Develop and Implement Abuse Policy Correction` CN A's 19, 20, 21, and 22 were educated on the abuse policy and appropriate notification procedure on 2-17-12. Contract therapists 8, 10, 11, 14, 15, 16, 17, and 18 were educated on the abuse policy and appropriate notification procedure between 2-15-12 and 2-22-12. Contract employees 6, 7, 9, 2, and 13 will no longer work at Parkview Haven per the contractor. Residents 29 and 14 experienced no harm from cited deficiencies as the original investigations of alleged abuse had confirmed that abuse had not occurred. New Nurses #2 and #5, and new C N A's #3 and #4 received immediate training on the abuse prevention policy by February 2, and will receive current training with all other employees before 2-24-12. Identification: The deficient practice has the potential to affect all residents, so plant-wide training was and will be conducted as described below. System Change: The Abuse Prohibition Policy was reviewed and revised to state that any new employee or contracted employee will receive training on abuse prohibition before starting to work. The Policy was also	02/24/2012

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	on 01/31/12, titled, " Primary Policy Abuse Prohibition " , indicated, " ...Abuse reporting forms can be obtained from: the office, social services or medical records. Abuse reporting forms need to be completely filled out and returned to social services, in the event that the report is against social services the report will then need to be returned to the administrator...PROCEDURE TO REPORT SUSPECTED ABUSE, NEGLECT OR MISAPPROPRIATE OF RESIDENT PROPERTY: 1. REQUEST INCIDENT ABUSE REPORTING FORM FROM OFFICE, SOCIAL SERVICES, OR MEDICAL RECORDS. 2. COMPLETELY FILL OUT FORM. 3. RETURN FORM TO SOCIAL SERVICES (OR TO ADMINISTRATOR , IF COMPLAINT IS AGAINST SOCIAL SERVICES.) 4. ENSURE PATIENT SAFETY. (THIS MAY REQUIRE NOTIFYING CHARGE NURSE OR D.O.N. ASAP (as soon as possible). 5. YOU WILL BE CONTACTED IF ANY QUESTION AND/OR TO REPORT INCIDENT FOLLOWUP (sic)...All staff will report any suspected abuse...per the ' Investigation of Abuse " policy...Alleged Violation Procedure & Protection of Resident 1. Notify the Social Services Director, D.O.N. or the administrator immediately of any alleged violation...For		reviewed and revised to state that abuse will be reported immediately to the administrator, that the administrator will report allegations of abuse to the ISDH, the Adult Protective Services, and to the Ombudsman within 24 hours of the alleged incident, and that investigations will consist of components which will guarantee thoroughness. The social services director or charge nurse will chart that the administrator has been notified of the allegation of abuse. The entire staff, including contracted employees, will be trained on the definition of abuse, on the entire abuse prevention policy, and specifically will be trained that suspected abuse must be reported immediately to the administrator. Emphasis will be placed on resident protection resulting from immediate notification. The staff and contracted employees will be trained that according to the Elder Justice Act, crimes must be reported immediately to the administrator and to the local sheriff. Training will occur by 2-24-12. The administrator, and in his absence the Director of Nursing, will report allegations of abuse within 24 hours to the Indiana State Department of Health, Adult Protective Services, and to the ombudsman and other pertinent authorities. The administrator will conduct thorough investigations and will retain investigation materials.	

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	notification use Abuse Reporting Form from file at Nurses Desk. 2. the administrator will co-ordinate all investigative procedures and notify other officials in accordance with State law...4. During the investigation process, (facility name), will take steps to prevent further potential abuse including, but not limited to:...Restriction of alleged staff or other agencies from serving the individual; 4.3 Suspension without pay of any facility staff involved in the alleged violation... " A. 1. Review of a "Facility Incident Reporting Form" indicated the incident date was 07/17/11 at approximately 1 p.m. The form indicated, "...(CNA #19) reported to DON (Director of Nursing) on 07/19/11 that on 07/17/11 CNA (CNA #20) was assisting resident (Resident #29) to toilet and she hers (CNA #20) say to (Resident #29) if you don't help me I am going to leave you on the toilet until 9 pm..." This allegation was reported to the DoN and the investigation was initiated two days after the incident occurred. The form indicated the DoN reported the allegation to the ISDH on 07/20/11, which was 3 days after the incident had occurred. The investigation lacked documentation to indicate the facility's Administrator had been notified of the allegation.		Since many resident behaviors may also be abuse, the behavior management book has been supplemented with a reference to abuse definitions and abuse reporting requirements. All employees wereor will be trained on this by 2-24-12. Monitor For one month on a weekly basis the administrator or his designee will confirm that all new employees have been trained on abuse prevention before starting to work. When four consecutive weeks have occurred with 100% compliance, the administrator or his designee will audit once a month. When six consecutive months have occurred with 100% compliance, the Grassroots Quality Committee will decide on the need and frequency of further monitoring. The Grassroots Quality Committee will be provided monthly reports until that point is reached. Allegations will be reviewed in daily inter-disciplinary stand-up meetings, watching especially for timeliness of reporting to the administrator, and timeliness of the administrator reporting to the ISDH. The Director of Nursing will review each allegation's investigation for thoroughness and timely reporting. Abuse Allegations will be reviewed by the Social Services Consultant bi-monthly. Abuse allegations will be discussed at the Monthly Quality Improvement meeting for trends and prevention and	

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	CNA #20's employee time card indicated CNA #20 continued to work on 07/17/11 from 11 a.m. to 2:30 p.m., 2:30 p.m. to 6:30 p.m., 6:45 p.m. to 9 p.m., 07/18/11 from 2:30 p.m. to 5:45 p.m. and 6:15 p.m. to 9 p.m., after the allegation had been made. During an interview on 01/31/12 at 2:05 p.m., the Administrator indicated CNA #19 should have reported the allegation immediately. He indicated after the allegation was reported on 07/19/11, CNA #20 did not work on 7/19/11. During an interview on 02/01/12 at 10:05 a.m., the Administrator indicated he could not say when he was notified. He indicated the DoN immediately notified him as she was doing the investigation. He indicated the DoN showed him the investigation before she sent it to the ISDH. He indicated the facility's policy was not followed. A. 2. Review of a "Facility Incident Reporting Form" indicated the incident date was 11/06/11 at 6:30 a.m.. The form indicated, "Early Sunday a.m. (11/06/11) (CNA #21) was working on the day shift--usually she works nights. (CNA #21) went into (Resident #14's) room to assist her...Later in the morning (Resident #14)		recommendations for further or revised training. Date of Compliance 2-24-12	

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	told another CNA, (CNA #22) that (CNA #21) is mean to her..." The form indicated the Administrator started the investigation on 11/07/11, which was 24 hours after the allegation occurred. A behavior monitoring record, dated 11/6/12 at 7:00 a.m. to 9:00 a.m., indicated, "Resident was telling other staff members that I was mean to her...Told CNA that she does not want me in her room to help her ever again." The behavior monitoring record was signed by CNA #21 and CNA #22. A handwritten note, dated 11/07/11 (one day after allegation), signed by CNA #21, indicated, "Just a heads up. Had some issues come up yesterday with (Resident #14)...(CNA #22) pushes her out to breakfast and the entire time she (Resident #14) told her how mean I was and that she never wants me in her room again. Found out this morning from (CNA #20) that she told her that I yelled at her...Now when I went in to take her to the bathroom tonight she was ok with me until she asked me my name...She rolled her eyes and didn't say another word to me...She rang again later on and this time (CNA #22)...went down. (Resident #14) asked (CNA #22) her name. She answered oh good I'm glad it's not that (CNA #21) again. I don't want her in			

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	here... " The fax cover form indicated the allegation of abuse was reported to the ISDH by the Administrator on 11/08/11, which was 48 hours after the allegation was made. The Nursing Schedule indicated CNA #21 continued to work at the facility on 11/06/11 and 11/07/11. During an interview on 02/02/12 at 9:50 a.m., the Social Service Director indicated the allegation occurred on 11/06/11 at 6:30 a.m. She indicated the CNA's wrote it in the behavior book. She indicated possibly the reason they were not notified of the allegation on 11/06/11 was because it was a Sunday. She indicated CNA #21 finished her shift on 11/06/11 after the allegation had been voiced by the resident. During an interview on 02/02/12 at 9:50 a.m., the Administrator indicated CNA #21 had, "told on herself " on the behavior sheet. He indicated CNA #21 should have reported the allegation immediately. He indicated the facility's policy was not followed. B. The facility's undated abuse policy, received as current by the Administrator on 01/31/12, titled, " Primary Policy			

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	Abuse Prohibition," indicated, " .....Training on Abuse Prohibition...will be conducted on day 3 of New Employee Orientation..." B. 1. Employee records were reviewed on 2/1/12 at 1 p.m. The 4 of 4 new employee records (RN #2, CNA #3, CNA #4 and RN #5) lacked documentation of abuse training. During an interview on 2/1/12 at 1:55 p.m., The Human Resource (HR) Director, indicated he would look for the abuse training for the employees. He indicated RN #5 had not been trained on abuse yet. He indicated she had oriented on the floor with another nurse yesterday (1/31/12). The new employee record form indicated: RN #2's start date at the facility was 11/21/11. CNA #3's start date at the facility was 10/6/11. CNA #4's start date at the facility was 10/28/11. RN #5's start date at the facility was 1/18/12. There was a lack of documentation in all the above employee records of abuse training. During an interview on 2/1/12 at 3:12			

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	p.m., the HR Director indicated RN #2 had received the abuse training "today." He indicated she had somehow gotten missed. He indicated the abuse training was supposed to have been done on the computer but he did not know why it had not been completed. He indicted he was responsible to make sure the training had been completed. He indicated he did monthly orientation for new employees. He indicated the start date on the employee record form was not the date the employees had actually started working. He indicated RN #2 had started working on the floor on 12/9/11 and she attended the next monthly orientation on 1/3/12, but had not done the abuse training. RN #5's start date on the form was 1/18/12 but she had started on the floor on 1/31/12. He indicated RN #5 had been trained on abuse today 2/1/12. During an interview on 2/1/12 at 3:53 p.m., the HR Director indicated he was unable to find any abuse training for CNA #3. He indicated CNA #4's start date was 10/28/11 and she had started working on 11/3/11. He indicated her abuse training was completed on 1/4/12. The HR Director provided post test for abuse for RN #2, dated 2/1/12, on 2/2/12 at 10:45 a.m.			

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	Review of a work detail report for RN #2, provided by the HR Director on 2/2/12 at 8:35 a.m., indicated RN #2 had worked 12/9/11, 12/13/11, 12/14/11, 12/17/11, 1/2/12, 1/3/12, 1/4/12, 1/5/12, 1/9/12, 1/10/12, 1/11/12, 1/14/12, 1/15/12, 1/16/12, 1/17/12, 1/19/12, 1/23/12, 1/24/12, 1/25/12, 1/26/12, 1/30/12, 1/31/12, and 2/1/12 without being trained on abuse. The HR Director provided post test for abuse for CNA #3, dated 11/1/11, on 2/2/12 at 8:35 a.m. Review of a work detail report for CNA #3, provided by the HR Director on 2/2/12 at 8:35 a.m., indicated CNA #3 had worked on 10/10, 10/11, 10/12, 10/13, 10/15, 10/16, 10/18, 10/19, 10/20, 10/21, 10/24, 10/25, 10/26, 10/27, 10/29, and 10/30/11 without being trained on abuse. The HR Director provided inservice training form for CNA #4 on 2/2/12 at 10:45, which indicated CNA #4 had attended abuse training on 1/4/12. Review of a work detail report for CNA #4, provided by the HR Director on 2/2/12 at 8:35 a.m., indicated CNA #4 had worked on 11/3/11, 11/4/11, 11/5/11, 11/6/11, 11/9/11, 11/14/11, 11/18/11,			

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	11/19/11, 11/20/11, 11/28/11, 12/7/11, 12/9/11, 12/10/11, 12/12/11, 12/13/11, 12/15/11, 12/16/11, 12/17/11, 12/18/11, 12/21/11, 12/31/11. 1/1/12, 1/2/12, and 1/3/12 without being trained on abuse. The HR Director provided post test for abuse for RN #5, dated 2/1/12, on 2/2/12 at 10:45 a.m. Review of a work detail report for RN #5, provided by the HR Director on 2/2/12 at 8:35 a.m., indicated RN #5 had worked on 1/31/12 without being trained on abuse. During an interview on 2/2/11 at 10:02 a.m., the HR Director indicated going forward they would be doing abuse training upon hire. B. 2. An interview on 2/2/12 at 1:55 p.m., the Human Resource Director indicated Therapist #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18 had not been inserviced by the facility for abuse training and training for the Elder Justice Act. The Human Resource Director indicated the therapists were contracted and had been inserviced by the therapy company. The Human Resource Director indicated the therapists had only been trained on Resident Rights by the therapy company and had not been inserviced on the facility's policies for			

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	abuse and the Elder Justice Act. Information provided by the facility on 2/02/12 at 1:50 p.m., indicated a faxed "Handbook Acknowledgment," dated 11/03/11. The information highlighted in green indicated the therapists had been inserviced on "Resident Rights." The information indicated "E. Dignity, Respect, and Freedom...3. The right to be free from mental and physical abuse." The therapy service contract, provided by the facility on 2/2/12 at 2:30 p.m., indicated the contract agreement had been in effect since 10/01/11. 3.1-28(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	A. Based on record reviewed and interview, the facility failed to ensure laboratory services were completed as ordered for 2 of 10 residents reviewed for laboratory tests in a sample of 10. (Resident #5 and #32) B. Based on observation, record review, and interview, the facility failed to ensure qualified staff administered oxygen for for 1 of 4 residents with oxygen in a sample of 10 residents. (Residents #5), related to a CNA adjusting oxygen flow rates. (CNA #1) Findings include: A.1. Resident #5's record was reviewed on 1/31/12 at 3:08 p.m. Resident #5's diagnoses included, but were not limited to, hypertension, congestive heart failure, and anxiety. An order, dated 1/2/12, indicated CBC with diff (Complete Blood Count, blood test), lipid panel (blood test for cholesterol), BMP (Basic Metabolic Panel), PSA (blood test for prostate), T4 free serum and TSH (blood tests for thyroid), and vitamin D every 6 months.	F0282	The facility is requesting paper compliance for this deficiency. Correction: No residents were adversely affected by the alleged deficiency. Ress #5 MD notified of Vitamin D level not being drawn: new order for Vitamin D level to be drawn yearly starting March 2012 received. Res # 32 MD notified of TSH level not being drawn: new order for TSH level to be drawn yearly starting March 2012 received. Res # 5 Oxygen checked on 1-31-12 with MD orders by the MDS Coordinator and oxygen was on the ordered liter flow. **Identification:** All residents that have physician orders for labs and/or oxygen have the potential to be affected. Physician orders will be audited on all resident s with lab orders to assure lab orders were followed. MD will be notified of any labs that were not completed per orders. All residents with oxygen orders will be audited and all Nursing staff was notified immediately of the CNA/QMA inability to turn on portable oxygen tanks and adjust liter flow. **System Change:** Reviewed and re-educated nursing staff on Lab policy and procedure and lab requisition form. All nurses was in serviced on following MD orders for labs and the lab policy and procedure	02/20/2012

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	The above labs were drawn on 1/17/12. The resident's record lacked documentation a vitamin D level was drawn. A lab requisition, dated 1/16/12, lacked documentation of a vitamin D level to be drawn. During an interview with the DoN (Director of Nursing), on 2/2/12 at 2:35 p.m., she indicated the vitamin D level was not drawn and the physician was notified. A. 2. Resident #32's record was reviewed on 1/31/12 at 3:35 p.m. Resident #32's diagnoses included, but were not limited to hypothyroidism, glaucoma, and chronic obstructive pulmonary disease. The physician order recapitulation, dated 1/12, indicated an order, dated 9/8/09, for a TSH (thyroid test) every six months. The resident's record indicated the last TSH was drawn on 3/10/11. There was a lack of documentation of any further laboratory test results in the resident's record of a TSH in September or any further TSH laboratory results through 1/31/12.. During an interview on 2/1/12 at 10 a.m.,		on 2-15-12. Oxygen Policy and Procedure reviewed and updated to include the statement that Only RN/LPNs are able to turn on portable oxygen tanks or adjust liter flow rates. All nursing staff will be educated/in serviced on the oxygen policy and procedure including the inability of the CNA/QMAs turn on portable oxygen tanks or adjust the flow rate of any oxygen on 2-15-12. **Monitoring:** New audit form in place: DON or designee will audit labs due to be drawn. This will be done Monday thru Friday with Monday's audit to include the weekend x 4 weeks. When 4 consecutive weeks have been completed with 100% accuracy the audit will be completed one time weekly x8 weeks.When 8 consecutive weeks have been completed with 100% accuracy the audit will be completed one time a month x 3months for a total of 6 months. After 100% accurracy for 6 months the QA committee will review the need for further auditing. The DON or designee will summarize the results of the audit and present to the QA committee monthly for review to identify additional trends/patterns warranting further corrective actions. Results of the audit will be reviewed monthly by the QA committee to determine the need for further auditing or if compliance has been determined and auditing may be stopped. DON or designee will do walking	

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	the Director of Nurses indicated the TSH had not been drawn as ordered. A facility policy, titled "Lab and Diagnostic Test Results-Clinical Protocol," dated April 2007, and received as current from the MDS (Minimum Data Set) Nurse, on 2/2/12 at 11:25 a.m., indicated "Assessment and Recognition 1. The physician will...order diagnostic and lab testing...2. The staff will process test requisitions and arrange for tests..." B. 1. An interview on 1/31/12 at 2:40 p.m., with CNA #1 indicated, "All of us put the portables (portable oxygen tanks) on and turn it to the correct oxygen level." An interview on 1/31/12 at 2:45 p.m., with RN #2 indicated the CNAs put the residents' portable oxygen tanks on and turn the portable oxygen tanks on. An interview on 1/31/12 at 2:42 p.m., with the MDS (minimum data set) Coordinator indicated the CNAs turn the portable oxygen tanks. CNA #1 was observed on 1/31/12 at 2:47 p.m., filling up a portable oxygen tank in the oxygen room. CNA #1 was observed placing the portable oxygen tank on Resident #5's wheelchair and turning the		rounds to observe and assure that cnas/qmas are not turning on portable oxygen tanks or adjusting any oxygen flow rates 5 times a week on alternating shifts x4 weeks .When 4 consecutive weeks have been completed with 100% compliance the audit will be performed 3 times weekly x 4 weeks on alternating shiftsWhen 4 consecutive weeks have been completed with 100% compliance the audit will be performed 2 times weekly on alternating shifts x 4 weeks. When 4 consecutive weeks have been completed with 100% compliance the audit will be performed 1 time weekly x 4 weeks on alternating shifts. When 4 consecutive weeks have been completed with 100% compliance the audit will be performed 1time monthly x 2 months on alternating shifts for a total of 6 months. After 100% compliance for 6 months the QA committee will review the need for further auditing. The results of the audit will be reviewed in the monthly QA meeting to determine the need for further auditing or determine if compliance has been achieved and auditing can be stopped.. Date of completion: 2-20-2012	

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	oxygen level to 2 liters. The CNA indicated she had turned the oxygen on to 2 liters. Resident #5's record was reviewed on 1/31/12 at 3:08 p.m. Resident #5's diagnoses included but were not limited to, congestive heart failure, anxiety, and shortness of breathe. A physician's order, dated 10/28/11, indicated the resident's oxygen level was to be set at 2 liters to keep the resident's oxygen saturation levels above 90%. An interview on 2/01/12 at 10:30 a.m., the DoN (Director of Nursing) indicated she was unaware the CNAs could not set or adjust the residents' oxygen flow rate. 3.1-35(g)(2)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered by the physician for 1 of 4 residents with oxygen in a sample of 10 residents. (Residents #5) Findings include: An interview on 1/31/12 at 2:40 p.m., with CNA #1 indicated, "All of us put the portables (portable oxygen tanks) on and turn it to the correct oxygen level." An interview on 1/31/12 at 2:45 p.m., with RN #2 indicated the CNAs put the residents' portable oxygen tanks on and turn the portable oxygen tanks on. An interview on 1/31/12 at 2:42 p.m., with the MDS (minimum data set) coordinator indicated the CNAs turn the portable oxygen tanks. CNA #1 was observed on 1/31/12 at 2:47	F0328	**F328: The facility is requesting paper compliance for this deficiency.** **Correction: No Residents were adversely affected by the alleged deficiency.** Res # 5 Oxygen checked on 1-31-12 with MD orders by MDS Coordinator and oxygen was on the ordered liter flow. **Identification:** All residents that have physician orders for oxygen have the potential to be affected. All residents with oxygen orders will be audited and all Nursing staff was immediately notified of the CNA/QMA inability to turn on portable oxygen tanks and adjust liter flow. **System Change:** Oxygen Policy and Procedure reviewed and updated to include the statement that Only RN/LPNs are to turn on portable oxygen tanks or adjust liter flow rates. All nursing staff will be educated/in serviced on the oxygen policy and procedure including the inability of the CNA/QMAs turn on portable oxygen tanks or adjust the flow rate of any oxygen on 2-15-2012. **Monitoring:** DON or	02/20/2012

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	p.m., filling up a portable oxygen tank in the oxygen room. CNA #1 was observed placing the portable oxygen tank on Resident #5's wheelchair and turning the oxygen level to 2 liters. The CNA indicated she had turned the oxygen on to 2 liters. Resident #5's record was reviewed on 1/31/12 at 3:08 p.m. Resident #5's diagnoses included but were not limited to, congestive heart failure, anxiety, and shortness of breathe. A physician's order, dated 10/28/11, indicated the resident's oxygen level was to be set at 2 liters to keep the resident's oxygen saturation levels above 90%. An interview on 2/01/12 at 10:30 a.m., the DoN (Director of Nursing) indicated she was unaware the CNAs could not set or adjust the residents' oxygen flow rate. 3.1-47(a)(6)		designee will do walking rounds to observe and assure that cnas/qmas are not turning on portable oxygen tanks or adjusting any oxygen flow rates 5 times a week on alternating shifts x4 weeks .When 4 consecutive weeks have been completed with 100% compliance the audit will be performed 3 times weekly x 4 weeks on alternating shiftsWhen 4 consecutive weeks have been completed with 100% compliance the audit will be performed 2 times weekly on alternating shifts x 4 weeks. When 4 consecutive weeks have been completed with 100% compliance the audit will be performed 1 time weekly x 4 weeks on alternating shiftsWhen 4 consecutive weeks have been completed with 100% compliance the audit will be performed 1time monthly x 2 months on alternating shifts for a total of 6 months After 100% compliance for 6 months the QA committee will review the need for further auditing. The results of the audit will be reviewed in the monthly QA meeting to determine the need for further auditing or determine if compliance has been achieved and auditing can be stopped.. Date of completion: 2-20-2012	

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F0504 SS=D	The facility must provide or obtain laboratory services only when ordered by the attending physician.			
	Based on record review and interview, the facility failed to ensure laboratory tests were completed only as ordered by the physician for 1 of 10 residents reviewed for laboratory services in a total sample of 10. (Resident #28) Findings include: Resident #28's record was reviewed on 1/30/12 at 1:15 p.m. Resident #28's diagnoses included, but were not limited to, arterial fibrillation and congestive heart failure. A physician's order, dated 6/21/11, indicated routine labs for a lipid panel (blood test), hepatic function panel (liver blood test) and a T4 free serum (blood test for thyroid) every month. Resident #28's record indicated the lab results for the the blood work completed on 11/28/11, indicated the resident had a digoxin level (blood test for a heart medication) completed also. The resident's December 2011 physician's orders lacked documentation of digoxin level being ordered in the routine labs. The December 2011 physician's orders	F0504	**F504: The facility is requesting paper compliance for this deficiency Correction: No Residents were adversely affected by the alleged deficiency** Res # 28 MD notified of Digoxin level drawn without MD orders. **Identification:** All residents that have physicians orders for labs have the potential to be affected. Physician orders will be audited on all resident s with lab orders to assure lab orders were followed. MD will be notified of any labs that were drawn without orders. **System Change:** Reviewed and re-educated nursing staff on Lab policy and procedure and lab requisition form. All nurses will be in serviced on following MD orders for labs and the lab policy and procedure on 2-15-2012. **Monitoring:** New audit form in place: DON or designee will audit labs due to be drawn. This will be done Monday thru Friday with Mondays audit to include the weekend x 4 weeks. When 4 consecutive weeks have been completed with 100% accuracy the audit will be completed one time weekly x8 weeks.When 8 consecutive weeks have been completed with 100% accuracy the audit will be completed one time a month x 3months for a total of 6 months.After 100% accurracy for 6 months the QA	02/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/03/2012
NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	also lacked documentation of the resident being on the heart medication of digoxin. An interview on 1/31/12 at 11:16 a.m., the DoN (Director of Nursing) indicated she did not know why the digoxin level was drawn as it was not on the physician's orders. 3.1-49(f)(1)		committee will reivew the need for further auditing. The DON or designee will summarize the results of the audit and present to the QA committee monthly for review to identify additional trends/patterns warranting further corrective actions. Results of the audit will be reviewed monthly by the QA committee to determine the need for further auditing or if compliance has been determined and auditing may be stopped.	