

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 12/17/2013
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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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F000000	<p>This visit was for the Investigation of Complaints IN00140288 and IN00140577.</p> <p>Complaint IN00140288 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00140577 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250.</p> <p>Survey dates: December 16 and 17, 2013</p> <p>Facility number: 000013 Provider number: 155038 AIM number: 100266100</p> <p>Survey team: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 65 SNF: 3 Total: 68</p> <p>Census payor type: Medicare: 6 Medicaid: 62 Total: 68</p>	F000000	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report."We respectfully request that your office will accept this plan as our facility's compliance and that you will consider a desk review as the one tag cited is not deemed to be actual harm or immediate jeopardy. Please review our attachments with the one cited deficiency as an audit tool.If you have any questions, please contact me at (765)289-3341. Thank you in advance for your immediate attention in this matter.</p>	
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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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	<p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			
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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medically related social services were provided to ensure staff responded appropriately and discontinued interaction and/or summoned assistance during an episode of catastrophic resident behavior resulting in resident bruising for 1 of 3 residents reviewed with combative behaviors in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>During an observation with RN #6 on 12/17/13 at 10:40 a.m., Resident #D was up in her chair. She had a fading dark bruise approximately one inch long on her left upper cheekbone. There was a shadow of grayish bruising all around her left eye and eye lid. There was a shadow of grayish bruising around the outer left side of her mouth. There was an area, measured by RN #6 as 7.4 cms by 4.5 cms (centimeter), of a dark fading bruise on the left inner forearm.</p>	F000250	<p>The resident (resident #D) affected by this deificent practice was reiewed by the IDT. Care plans and CNA assignment sheets where updated to reflect appropriate inverventions to be taken if resident becomes combative during ADL care and or other circumstances. The IDT will review all residents known to have adverse reactions to ADL care. Care Plans and CNA assignments will be updated to reflect appropriate interventions to be taken if the resident becomes combative during ADL care or other circumstances. This will be completed no later than 01/16/2014. All staff will be re-educated/in-serviced on the "Mood and Behavior Crisis Managment" Policy and Procedure. This was started on 12/18/2013 and will be completed on 01/16/2014. The pyscholgist, who provides psych services in-house will in-service all staff on effective techniques of dealing with catastrophic mood and behaviors no later than 01/16/2014. All reportable occurances are brought to the IDT and reviewed. The review will include review of the Incident and Accident Report, Nurses Notes,</p>	01/16/2014			

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	<p>The clinical record for Resident #D was reviewed on 12/16/13 at 4 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, degenerative joint disease, paranoid schizophrenia, dementia, depression, and anxiety.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 11/16/13, indicated the resident was severely cognitively impaired. The assessment indicated the resident had problems with delirium including inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation. The assessment indicated the resident required extensive assistance from the staff for all activities of daily living.</p> <p>A health care plan problem, dated 10/8/13, indicated the resident had behavioral symptoms that could be harmful to self or others or interfere with function of care which included, verbally abusive and physically abusive behavior with a history of hitting and scratching. Interventions for this problem included, but were not limited to, "approach calmly, explain care to be given, assess for pain and physical needs, provide reassurance, validate feelings, and</p>		<p>Witness Statements, Social Service Notes, or any documentation that could be related to the occurrence (i.e., labs, physicians orders, psych histories). The IDT will review to ensure the Responsible Party, Administrator, DON, Physician, local law enforcement (if needed) were notified. Evaluation will include change in interventions, reason's for change, and effectiveness of the intervention. The IDT will initiate or update the Mood and Behavior Symptom Care Plan as applicable. The IDT will provide re-education in an individual or group setting as needed upon review of any mood or behavioral event where the staff did not react in a manner that was appropriate to the situation as well as any other applicable care plans. The Administrator/DON or Designee will review all reportables to ensure that the reportables have been reviewed by the IDT and interventions were in place, and that care plans and assignments sheets have been updated, and education has been conducted, as needed, given the situation. The review of the reportables will be documented on "Clinical Review of Reportable Incident Form" and reviewed as needed by the IDT. The Administrator or Designee will review the forms weekly to ensure they are completed and signed off. The reportable review</p>		

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	<p>when combative-reapproach at another time."</p> <p>A psychological consultant note, dated 11/19/13, indicated the resident had been seen on that date due to an exacerbation of behaviors and symptoms including a recent resident to resident altercation. The note indicated the resident had a long history of verbal aggressiveness and inappropriate social behavior. Two interventions in the "action plan" for Resident #D were for the staff to "respect resident's right to make decisions independently and refrain from trying to influence him/her toward more logical decisions and identify behaviors that are unacceptable and withdraw attention immediately for these behaviors."</p> <p>Review of a follow-up facility reported incident completed by the DoN, dated 12/12/13, indicated the following:</p> <p>A day shift CNA noted a red area on Resident #D's face on 11/28/13 at 6:30 a.m. and informed the day shift nurse of the area. During an examination of the resident, two bruises were noted on the resident's face and one on her left forearm. The bruise by the left eye measured 2.5 centimeters (cm) by 4 cm. The bruise</p>		<p>will be done weekly for 52 weeks, and the Administrator will review for compliance weekly using the audit tool. Any concerns will be immediately addressed, up to and including 1:1 re-education, and disciplinary action. The Performance Improvement Plan (PIP) is reviewed weekly as party of the Qapi. Results of the investigation will be forwarded to the Quality Performance Improvement Committee monthly for 12 months. Any future action will be as determined by the QPI.</p>				

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	<p>on the left side of the resident's mouth measured 1 cm by 2 cm. The bruise on the left forearm measured 5.5 cm by 4.5 cm, and had 3 half moon marks noted within the bruise. The Administrator and DoN were notified of the bruises and an investigation was completed.</p> <p>The investigation "Follow-up" was as follows:</p> <p>"The bruising on [name of resident] face and forearm was first noted on 11/28/13 at approximately 7:30 a.m. The staff members present in the building on the shifts prior to this time were individually interviewed. Investigation revealed that the bruising was not present on the night, evening, or day shift of 11/27/13. The resident was assisted with a shower early on the morning of 11/28/13 [later determined to have been showered late in the evening on 11/27/13] by 2 C.N.A's, [Name of CNA #1 and CNA #2]. Both [names of CNAs] report that immediately following her shower, while trying to dry her off and dress her, [name of resident] was 'combative', hitting, biting, kicking, and thrashing herself around' the C.N.A.'s also report that [name of resident] believed they were 'trying to kill' her rather than assist</p>			

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	<p>her. [Name of resident] injuries are a result of delusional beliefs that she was going to be 'murdered' during care causing her to thrash about, swinging her arms with force and inadvertently inflicted the bruising to her own face and mouth. The bruising to her forearm occurred as a result of staff attempting to guide [name of resident] arms into clothing during which time [name of resident] was swinging and forcing her arms away from staff who were attempting to assist her. [Name of resident] is prescribed medications which place her at an increased risk for bruising including Aspirin, Depakote, and Hydrocortisone."</p> <p>Review of the facility investigation, provided by the Administrator on 12/16/13 at 10:30 a.m., included, but were not limited to, the following written staff statements:</p> <p>CNA #1 indicated the date of the incident was 11/27/13 between 7 and 7:30 p.m. CNA #1 indicated "Me and [name of CNA #2] gave [name of resident] a shower and she didn't want us to touch her she said that she didn't want us touching her cause we wanted to kill her she kept tryna (sic) bite us and was biting the towel and her gown while we were trying to dry</p>				

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	<p>her off and put her clothes on. Then when we finally got her in her room she fought us the whole time till we got her brief on in her bed."</p> <p>CNA #2 indicated the date of the incident was 11/27/13 between 7 and 7:30 p.m. CNA #2 indicated "When giving [name of resident] a shower, she continually tried to hit, bite, and kick. She also was cursing and kept saying "don't put your damn hands on me. She was chewing on the towel and thrashing herself around."</p> <p>LPN #3 indicated the date of the incident was 11/27/13 (no time listed). LPN #3 indicated "There was no bruises on resident face when I saw resident. I helped [name of CNA #2) transfer resident to shower chair resident was calm. [Name of CNA #1] walked in to help. I exited shower room. Resident did start yelling right before resident and before resident and CNA's brought out resident. CNA's did not tell me she was fighting staff or not. Resident did have a bowel movement."</p> <p>CNA #1 was interviewed on 12/16/13 at 1:20 p.m. She indicated she heard Resident #D yelling from the shower room around 7-7:30 p.m. on 11/27/13. She indicated the resident</p>			

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	<p>was yelling something like "keep your hands off me". CNA #1 indicated she went into the shower room to assist because Resident #D was familiar with her and CNA #2 was a new CNA to the facility. CNA #1 indicated LPN #3 and CNA #2 had just transferred the resident into the shower chair. She indicated Resident #D was upset, but calmed down when the shower was being given. She indicated the resident became very upset and combative when the two CNAs were attempting to dry her off and get her dressed. She indicated she tried to calm the resident, but was unable to redirect her and the resident continued to kick and swing out at the staff. CNA #1 indicated she tried to prevent the resident from hurting herself and was unaware of any bruising until the next day.</p> <p>LPN #3 was interviewed on 12/16/13 at 3:45 p.m. She indicated she had helped CNA #2 transfer Resident #D into the shower chair prior to her shower on 11/27/13. She indicated Resident #D was calm. LPN 3# indicated she did hear the resident "yelling" from the shower room later but this was not out of the ordinary for her and she did not reenter the shower room. She indicated the CNAs did not come and get her</p>			

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	<p>related to the resident being combative, but she was not the resident's primary nurse that night.</p> <p>LPN #4 was interviewed on 12/16/13 at 4:25 p.m. She indicated she was Resident #D's primary nurse on the evening of 11/27/13. She indicated the CNAs did report to her that the resident had been combative during care until after the shower was completed and the resident was placed in bed. She indicated she gave the resident her routine medications around 8 p.m. that evening and she was calm at the time. She indicated she did not see any bruising on the resident during the medication pass. LPN #4 indicated the resident frequently got upset in the shower and was delusional. She indicated the resident frequently believed someone was trying to kill her.</p> <p>CNA #1 was interviewed on 12/16/13 at 3:45 p.m. When queried if the CNAs had stopped attempting to dry and dress the resident after the shower and have one of them go and get the nurse on duty for assistance when the verbal and physical resident behavior could not be redirected, she indicated "no".</p>			

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	<p>The Administrator, DoN, Social Services Director, and Education Training Director were interviewed on 12/16/13 at 10:20 a.m. When queried if any inservice or training had been completed with CNA #1, CNA #2, LPN #3, and/or and other staff related to appropriate staff response to a catastrophic resident reaction following the incident on the evening of 11/27/13, they all indicated "no".</p> <p>The Social Services Director indicated she was unaware of the resident being frequently combative when she was showered and would review the resident for this concern and update her plan of care as needed related to the incident.</p> <p>Review of the current facility policy, revised January 2008, titled "Mood and Behavior Crisis Management", provided by the Social Services Designee on 12/17/13 at 10:10 a.m., included, but was not limited to, the following:</p> <p>"...Procedure</p> <p>...2. Assess situation for immediate actions.</p> <p>3. Initiate/Implement measures to promote safety.</p>				

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	<p>Summon additional staff as needed ...Remain at a safe distance and speak calmly and firmly Remove resident from the situation to a safe, supervised environment. Identify and reduce and/or remove triggers of harmful behaviors as possible...."</p> <p>This federal tag relates to Complaint IN00140577.</p> <p>3.1-34(a)</p>			