CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO.			
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150021	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X3) DATE SURVEY COMPLETED 04/13/2016	
	PROVIDER OR SUPPLIER		11109	ADDRESS, CITY, STATE, ZIP CODE PARKVIEW PLAZA DRIVE WAYNE, IN 46845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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	
A 0000						
Bldg. 00	This visit was fo two Federal hosp Date: 4/11/16 -	•	A 0000			
	Facility Number	: 005020				
	Complaint Num IN00193613: Su deficiencies rela cited					
		nsubstantiated; lack of ace. Deficiency unrelated s is cited				
	QA: cjl 04/22/16					
A 0395 Bldg. 00	A registered nurse evaluate the nursi Based on docum interview, the nu ensure that nursi repositioning evaluations scoring risk for skin issu	N OF NURSING CARE e must supervise and ng care for each patient. ent review and ursing supervisor failed to ng staff documented ery 2 hours, for those as a moderate or high es, for 3 of 10 patients, nd #10 and nursing	A 0395	Describe what the facility of to correct the deficient practice for each client cited in the deficiency. Response: The staff on the unwhere the deficiency occurred of the staff of t	its	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

supervisor failed to ensure nursing staff

TITLE

policy expectations (documenting

(X6) DATE

Any defiency statement 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.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		150021	B. W	ING		04/13/	2016
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PARKVIEW PLAZA DRIVE		
D/V DK//II	EW REGIONAL ME	DICAL CENTER			VAYNE, IN 46845		
	- VV INEGIONAL IVIE	DIGAL CLIVIER		TOKTV			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	followed policy	& procedure for vital			turns every 2 hours for patient		
	signs for 2 of 10 patients (patient #3 and #8). Findings Include: 1. Review of the policy Skin Assessment and Prevention of Pressure Ulcers, no				who have a moderate to high score on the Braden Scale).	risk	
					Nursing Services will provide		
					documentation education with	a	
					PowerPoint presentation that	-	
					includes screen shots from the	е	
					electronic medical record.		
					Continual education during da		
		ast approved on 4/13,			huddles, monthly unit meeting	S,	
		aden scoring tool is			and one-to-one coaching.		
	utilized to assess	s possible skin issues for			2. Describe how the facility		
	patients.				reviewed all clients in the facil	itv	
	A. On page 5,	it reads that a score of 15			that could be affected by the	,	
	to 18 is Mild Ris	sk and the patient is to			same deficient practice, and		
		n: Mild Risk for			state, what actions the facility		
	_	5 - 18" with the nursing			took to correct the deficient		
					practice for any client the facil	ity	
	_	ion minimally every 2			identified as being affected.		
	hours if unable t				Response: A skin assessmer		
		it reads that for scores of			will be completed for all patier		
	13 - 14, a Modei	rate Risk, the patient is to			at risk for pressure sores or w		
	be "Reposition	ned minimally every 2			have pressure sores.		
	hours if unable t	o turn self".					
	C. On page 7,	it reads that for scores of			Describe the steps or		
		sk, the patient is to be			systemic changes the facility h		
	, ,	minimally every 2 hours			made or will make to ensure the		
	if unable to turn	, ,			the deficient practice does not recur, including any in-service		
		Sell			but this also should include ar		
					system changes you made.	' ^y	
		tient medical records			,		
	indicated:				Response:		
	A. Pt. #5 scor	red 14 (Moderate Risk)					
	on the Braden to	ool on admission 3/15/16.			a. Nurse leads will condu		
	It was also noted on:				audits per shift (4 total for eac		
		2200 hours that the			calendar day). Audits will cont		
	patient "turns se				until 90% compliance is attain for 3 consecutive months.	eu	
	-				ioi o consecutive months.		
	D. 3/10/10 at (0018 hours that the					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		150021	B. W	ING		04/13/2	016
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			PARKVIEW PLAZA DRIVE		
DVDK/\IE	W REGIONAL ME	DICAL CENTER			VAYNE, IN 46845		
	W REGIONAL ME	DICAL CENTER		FORT			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	rest" and needed "mod			b. System-wide review to		
	assist".				identify and close any gaps.		
	c. 3/16/16 lacl	ked documentation for			Describe how the correct	ive	
	repositioning from 0800 hours to 1252				action(s) will be monitored to		
	-	1400 hours to 2051			ensure the deficient practice w	/ill	
	hours.	1 100 110 110 10 200 1			not recur, i.e., what quality		
		m 0200 hours to 0710			assurance program will be put		
	d. 3/17/16 from 0200 hours to 0710 hours lacked documentation of				into place.		
		cumentation of			Desmana		
	repositioning.				Response:		
					Parkview Health Chief Nurs	ina	
	B. Pt. #6 scored 12 (High Risk) on				Executive will be responsible f	•	
	admission (3/15/	(16) according to the			implementing the education ar		
	Braden scoring t	ool and later scored 12,			audits.The system by which th	e	
	_	ther documentation			responsible person(s) will mor	nitor	
	included:				l		
		/surg nursing unit on			Nurse leads will conduct Nurse leads will conduct		
		19 hours to 0047 on			audits per shift (4 total for each calendar day). Audits will cont		
					until 90% compliance is attained		
	3/16/16 lacked re	-			for 3 consecutive months.		
		or on 3/16/16 from 0047					
	to 0421 and 042	1 hours to 0854 hours.			 Unit education will begin 	n	
	b. On 3/16/16,	in the ICU (intensive			May 10, 2016 and will be		
	care unit), there	was no every two hours			completed by June 01, 2016.		
	repositioning no	ted between 0854 hours			audits will begin June 01, 2016	o	
		and from 1200 hours to			until 3 consecutive months of 90% compliance is attained.		
	1500 hours.				90 % compliance is attained.		
		lacked documentation of					
		ery two hours between					
	0600 hours and 0	U9UU hours.					
	C. Pt. #10 was	a 68 year old admitted					
	on 4/11/16 with a Braden score initially						
	of 15 (Mild Risk	a) with other assessments					
	being 14 and 15.						
	_	, lacked repositioning					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150021		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 04/13/2016			ETED		
	PROVIDER OR SUPPLIER		<u> </u>	11109 F	DDRESS, CITY, STATE, ZIP CODE PARKVIEW PLAZA DRIVE VAYNE, IN 46845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	0600 hours; from hours b. Lacked reputer from 2300 on 4/4/13/16, and lack after 0612 hours review at 1206 html. 3. At 3:10 PM of on 4/13/16, inter #50 and #55, quaspecialists, confifor patients #5, #documentation expolicy and care prepositioning, or turning themselv. 4. Review of the Standards of Carpolicy number, I indicated on page to be taken at "A (sic), then every. 5. Review of the patient #3 indicated the PACU (post 1149 hours on 1 at 1150 hours, 1 hours with no fur	on 4/12/16 and 11:15 AM eview with staff members ality and accreditation fremed that documentation fe and #10 lacked every two hours, per colans, regarding that the patient was eves. The policy Clinical re Perioperative, no ast approved on 6/2015, fe 6: "Vital Signs" were admit/every 5 min x5					

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Event ID:

2F3511

Facility ID: 005020

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

PRINTED: 05/17/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150021		A. BUILDING B. WING	<u>00</u>	COMPLETED 04/13/2016	
	ROVIDER OR SUPPLIER		11109 F	ADDRESS, CITY, STATE, ZIP CODE PARKVIEW PLAZA DRIVE WAYNE, IN 46845	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	StandardsAdva ICU (intensive con Standards, no nurapproval, indicate in the critical or it to have document warming device and Admission; Vital minutes x 5, then (sic), then hourly warming the patient #8 indicate critical/intensive on 4/12/16 at 182 taken every 15 mm 1830 hours, 1845 1915 hours, 1930 8. At 11:30 AM with staff members accreditation spetthe post op VS for	ed patients who recover intensive care units are tation for: "Document and temperature on s on Admit then every 5 a every 15 minutes x7". I medical record for ted they went to the care unit after surgery 15 hours and had VS inutes at 1815 hours, 5 hours, 1900 hours, 1900 hours, 1900 hours, 1900 hours and 1945 hours. I on 4/13/16, interview or #55, a quality and cialist, confirmed that or patients #3 and #8 minutes x 5 as per			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2F3511

Facility ID: 005020

If continuation sheet Page 5 of 18

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l í	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
		150021	B. WI	NG		04/13/	/2016
	ROVIDER OR SUPPLIER		<u> </u>	11109 F	ADDRESS, CITY, STATE, ZIP CODE PARKVIEW PLAZA DRIVE NAYNE, IN 46845		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
A 0450 Bldg. 00	legible, complete, authenticated in w the person respon evaluating the serwith hospital policid Based on docum interview, the factompleteness of care unit) docum record for 1 of 3 reviewed, Patient Findings Include 1. Review of the Standards Advit ICU (intensive c Standards, no nu approval, indicat in the critical or to have document Admit then every 15 minutes 2. Review of m A. Patient #3 h was taken to PAC	record entries must be dated, timed, and ritten or electronic form by sible for providing or vice provided, consistent es and procedures. ent review and cility failed to ensure the PACU (post anesthesia entation in the medical surgical patient records t #3.	A 0	450	Describe what the facility did to correct the deficient practice for each client cited in the deficier. Provide education to nursin staff on the policy for documentingvital signs. Provide education for ICU at PACU nursing staff regardingverifying and validativital signs. Provide competency training and education for PACU nurses regarding extubation documentation requirements. Update Clinical Standards of Care Perioperative policy to to include extubation criteria for PACU nurses. Mandate staff review of the updated policy related to extubation Describe how the facility trevier all clients in the facility that coube affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facilityidentified as be	or ncy. g and ng g of r wed ald ent	06/30/2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2F3511

Facility ID: 005020

If continuation sheet Page 6 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		150021	B. W	ING		04/13/	2016
		<u></u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			PARKVIEW PLAZA DRIVE		
PARKVIE	EW REGIONAL ME	DICAL CENTER			WAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		hours, the patient was			affected. ·Nurse Leader will audit 2		
		being on the ventilator.			charts per day to verify		
	VS were taken a	at 1155 hours and 1200			documentation of vital signs.		
	hours. At 1205	hours no VS were			Audits will continue until 90%		
	charted and the	oxygen level was at 91%;			compliance is attained for		
		espirations were 13 and			3consecutive months.	- 0 /	
	the oxygen saturation was 92%, but no VS were taken. The medical record noted				·Nurse Leader will audit 100		
					cases with extubation in PAC	U	
		e was called at 1214			andreport audit findings and completion of education biwe	ekly	
					to qualitymanagement and th	-	
	1	pressions initiated.			leadership team. Any complia		
		nad a hospitalist note			issues will be addressedwith		
	written at 1255	hours on 1/22/16, and			responsible co-worker.		
	"filed" at 1328 h	nours, that indicated:			Describe the steps or system		
	"Called for code	blue. Patient sp (status			changes the facility has made		
	post) lap cholec	ystectomy. Developed			orwill make to ensure that the		
	^ ^ -	re post extubation and			deficient practice does not re- including anyin-services, but		
		EA (pulseless electrical			also should include any syste		
		cardio pulmonary			changes you made.		
		itiated. Patient was			Clinical Standards of Care		
		itiated. Tatient was			Perioperative policy will be		
	reintubated".				updatedto include extubation		
	2 Daview of the	e document related to the			criteria for PACU nurses Competency training and v	المير	
					as written education for	VCII	
		nittee evaluation on			PACUnurses regarding		
		nt #3's code indicated:			extubation documentation		
		as initiated. More than			requirements will be provided	l.	
	thirty (30) people	le responded. The first			Staff will sign off that they		
	endotracheal tub	e was placed and			reviewed and attest to		
	resuscitation eff	orts began. The Code			education of the updated police		
		first tube was pulled and			 Education for nursing staff regarding verifying andvalidate 		
	the second one placed and the ETCO2 (End-Tidal Carbon Dioxide) (winky) was used and confirmed the endotracheal tube				vital signs per the policy will b		
					provided	-	
					· In-service education of nur	sing	
					staff on the policy.		
		ositioned to ventilate the			Describe how the corrective		
	I lungs. After the	second intubation, the			action(s) will be monitored		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ED
		150021	B. W	ING		04/13/20	116
NAME OF	DDOMDED OF GUIDN TEL			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		11109 F	PARKVIEW PLAZA DRIVE		
PARKVI	EW REGIONAL ME	DICAL CENTER		FORT V	WAYNE, IN 46845		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE C	COMPLETION	
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	team got [the par	tient] back right away"			toensure the deficient practice not recur, i.e., what quality	e Will	
					assuranceprogram will be put	into	
	4. At 11:50 AM on 4/12/16 interview with staff member P1, the pre op nurse for patient #3 on 1/22/16, confirmed that				place.		
					·Nursing review of policy		
					completed by May 31, 2016.		
	they remembere	d the patient was "fully			 Nursing education regardir validating and verifying vital 	9	
	awake when ext	ubated" in the PACU,			signscompleted by May 31, 2	016.	
	prior to the arres	t.			·Competency training and		
	5. At 10:05 AM on 4/13/16, interview with PACU nurse #59 confirmed that				education for PACU nurses		
					regardingextubation		
					documentation requirements completed by May 31, 2016.		
	there was no oth	er nursing notes or			·Clinical Standards of Care		
	documentation i	n patient #3's medical			Perioperative policy updated		
		the patient's PACU time			toinclude extubation criteria b		
		ours (respirations and			PACU nurses by June 30, 20		
		on level) and 1214 hours,			 Mandatory staff review of t updated policy completed by 	ne	
		documentation related			May31, 2016.		
		ng extubated in PACU,			Who is responsible		
	and that criteria	•			·The Vice President of Nurs	ing	
	complete the ext				at the Randallia location will beresponsible for implementing		
	complete the ext	doution process.			education and ongoing	ig	
	6. At 11:15 AM	on 4/13/16, interview			compliance with this actionpla	ın.	
		er #55, a quality and					
		ecialist, confirmed that:					
	_	facility policy related to					
		s of medical records.					
	-	l record for patient #3					
		for documentation					
	•	ation time prior to a re					
		g the code blue, as noted					
	1	-					
		t who attended the code. rmed that there was no					
		tation between 1210					
	I hours and the co	de which began 1214			1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150021		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/13/2016			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
S 0000 Bldg. 00	hours. C. It was uncle PACU prior to the 1/22/16. This visit was foot two hospital lice. Date: 4/11/16 - 4 Facility Number. Complaint Number. IN00193613: Sur. Deficiencies citerallegations.	ar what occurred in the ne code of 1214 hours on r investigation of insure complaints. 4/13/16 1005020 Deers: bstantiated,	S 0000				
		ce, deficiency cited					

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 9 of 18

T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
	150021	B. WI	NG		04/13/	2016
		•	11109 F	PARKVIEW PLAZA DRIVE		
SUMMARY S	FATEMENT OF DEFICIENCIES		ID	BROWINERIC DI AM OF CORRECTION		(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
unrelated to the a	allegations.					
410 IAC 15-1.5-4						
	RD SERVICES					
410 IAC 15-1.5-4	(e)(1)					
shall be: (1) legible and cor	nplete;					
interview, the factompleteness of care unit) documerecord for 1 of 3 reviewed, Patient Findings Include 1. Review of the StandardsAdv. ICU (intensive constandards, no nuapproval, indicate in the critical or to have documered Admit then every every 15 minutes 2. Review of many A. Patient #3 have	eility failed to ensure the PACU (post anesthesia entation in the medical surgical patient records t #3. Example document Critical Care anced Post-Operative are unit) Patient Care mber or date of ed patients who recover intensive care units are station for: "Vitals on y 5 minutes x 5, then s x7 (sic), then hourly". Edical records indicated: ad surgery on 1/22/16,		44	did to correct the deficient practicefor each client cited in deficiency. Provide education to nursing staff on the policy for documentingvital signs Provide education fo ICU and PACU nursing staff regardingverifying and validat vital signs Provide competency training and education for PAC nursesregarding extubation documentation requirements. Update Clinical Standards of Care Perioperati policy toinclude extubation crifor PACU nurses Mandate staff review the updated policy related to extubation Describe how the facility reviewed all clients in the facilitythat could be affected b the same deficient practice, at	the r ing CU ive teria r of	06/30/2016
	ROVIDER OR SUPPLIER W REGIONAL MEI SUMMARY ST (EACH DEFICIENT REGULATORY OR Unrelated to the a QA: cjl 04/22/16 410 IAC 15-1.5-4 MEDICAL RECOF 410 IAC 15-1.5-4 (e) All entries in the shall be: (1) legible and combased on document interview, the fact completeness of care unit) document record for 1 of 3 reviewed, Patien Findings Included 1. Review of the StandardsAdval ICU (intensive constandardsAdval ICU (intensive constandards and in the critical or standards and in the critical or standards. Admit then every every 15 minutes 2. Review of many A. Patient #3 has taken to PAG W REGIONAL MEI SUMMARY ST. SUMMARY ST.	DEPTIFICATION NUMBER: 150021 ROVIDER OR SUPPLIER W REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record	ROVIDER OR SUPPLIER W REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care StandardsAdvanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "Vitals on Admit then every 5 minutes x 5, then every 15 minutes x 7 (sic), then hourly". 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with	ROVIDER OR SUPPLIER W REGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care StandardsAdvanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "Vitals on Admit then every 5 minutes x 5, then every 15 minutes x 7 (sic), then hourly". 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with	ROVIDER OR SUPPLIER WREGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1,5-4 MEDICAL RECOULATORY OR SUBMITIES OR ADDITIONAL MEDICAL RECOULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1,5-4 MEDICAL RECOULATORY OR SUBMITIES OR ADDITIONAL RECOULATORY OR LSC IDENTIFYING INFORMATION) Unrelated to the allegations. QA: cjl 04/22/16 410 IAC 15-1,5-4 MEDICAL RECORD SERVICES 410 IAC 15-1,5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care StandardsAdvanced Post-Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "Vitals on Admit then every 5 minutes x 5, then every 15 minutes x 7 (sic), then hourly". 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with the first VS (vital sizes) laken at 1150	ROVIDER OR SUPPLIER WREGIONAL MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES GEACT DEFICIENCY MUST BE PRECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) unrelated to the allegations. QA: eji 04/22/16 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 legible and complete; Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care StandardsAdvanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: " Vitals on Admit then every 5 minutes x 5, then every 15 minutes x 7 (sic), then hourly" 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 10 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		150021	B. WING		04/13/2016
			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			PARKVIEW PLAZA DRIVE	
PARK\/IF	EW REGIONAL MEI	DICAL CENTER		WAYNE, IN 46845	
				1	T
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
		hours, the patient was		for any client the facilityidentifi	ea
	documented as b	being on the ventilator.		as being affected. Nurse Leader will aud	Nit O
	VS were taken a	t 1155 hours and 1200		charts per day to verify	JIL 2
	hours. At 1205 l	hours no VS were		documentation of vital signs.	
		oxygen level was at 91%;		Audits will continue until 90%	
		•		compliance is attained for	
		espirations were 13 and		3consecutive months.	
	, , ,	ation was 92%, but no		·Nurse Leader will aud	dit
		The medical record noted		100% cases with extubation in	
	that a Code Blue	was called at 1214		PACU andreport audit findings	5
	hours with comp	ressions initiated.		and completion of education	
	B. Patient #3 h	ad a hospitalist note		biweekly to qualitymanagemen	חנ
		nours on 1/22/16, and		and the leadership team. Any compliance issues will be	
		ours, that indicated:		addressedwith the responsible	_
		-		co-worker.	
		blue. Patient sp (status		·Describe the steps or	
	^ ^ -	stectomy. Developed		systemic changes the facility h	nas
	respiratory failur	re post extubation and		made orwill make to ensure th	
	then went into P	EA (pulseless electrical		the deficient practice does not	
	activity). CPR (cardio pulmonary		recur, including anyin-service	
		tiated. Patient was		but this also should include an	У
	reintubated".			system changes you made.	
	Temudated			·Clinical Standards of Care Perioperative policy will I	
	2 Pavious of the	e document related to the		updatedto include extubation	J C
				criteria for PACU nurses	
		ittee evaluation on		Competency training	and
	_	nt #3's code indicated:		well as written education for	
	"Code Blue wa	as initiated. More than		PACUnurses regarding	
	thirty (30) people	e responded. The first		extubation documentation	
	endotracheal tub	e was placed and		requirements will be provided.	
		orts began. The Code		Staff will sign off that	
		first tube was pulled and		they reviewed and attest to	
		_		education of the updated policy	
	_	placed and the ETCO2		·Education for nursing staff regarding verifying	
	(End-Tidal Carbon Dioxide) (winky) was			andvalidating vital signs per th	e
	used and confirn	ned the endotracheal tube		policy will be provided	
	was correctly po	sitioned to ventilate the		·In-service education	of
		second intubation, the		nursing staff on the policy.	
]	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		150021	B. W	ING		04/13/	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8			PARKVIEW PLAZA DRIVE		
PARKVIE	W REGIONAL ME	DICAL CENTER			VAYNE, IN 46845		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		·		TAG		41	DATE
TAG	4. At 11:50 AM with staff memb for patient #3 on they remembered awake when extraprior to the arress. 5. At 10:05 AM with PACU nurse there was no oth documentation in record related to between 1210 ho oxygen saturation that there was no to patient #3 being and that criterial complete the extra complete the extra complete is no the completeness. B. The medical was incomplete related to extubation and the complete extra complete related to extubation.	ton 4/13/16, interview the #59 confirmed that the er nursing notes or in patient #3's medical the patient's PACU time the patient's pacurations and in level) and 1214 hours, of documentation relateding extubated in PACU, had been met to		TAG	Describe how the correct action(s) will be monitored toensure the deficient practice not recur, i.e., what quality assuranceprogram will be put place. Nursing review of policompleted by May 31, 2016. Nursing education regarding validating and verify vital signscompleted by May 3 2016. Competency training education for PACU nurses regarding extubation documentation requirements completed by May 31, 2016. Clinical Standards of Care Perioperative policy updatoinclude extubation criteria by PACU nurses by June 30, 201 Mandatory staff revier of the updated policy complete by May31, 2016. Who is responsible The Vice President of Nursing at the Randallia location will beresponsible for implementing education and ongoing compliance with this actionplan.	tive will into icy ing 1, and ated 6. w	DATE
	by the hospitalist who attended the code. It was also confirmed that there was no						
	PACU documen	tation between 1210					
	hours and the co	de which began 1214					

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

PRINTED: 05/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		150021	B. WING		04/13/2016
NAME OF I	NAME OF PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COI	DE .
				9 PARKVIEW PLAZA DRIVE	
PARKVI	EW REGIONAL ME	EDICAL CENTER	FOR	T WAYNE, IN 46845	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APP DEFICIENCY)	PROPRIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	hours.	ear what occurred in the			
	PACU prior to the code of 1214 hours on				
	1/22/16.				
S 0912	410 IAC 15-1.5-6				
	NURSING SERV				
Bldg. 00	410 IAC 15-15-6	(a)(2)(B)(ı)(ıı) (iv)(v)			
	(111)	('*)(*)			
	(a) The hospital s				
	organized nursing				
		our (24) hour nursing or supervised by a			
		The service shall			
	have the following				
	(2) A nurse execu				
	(B) responsible for (i) The operation				
	including, but not				
		ypes and numbers of			
	nursing personne	el and staff necessary			
	to provide care for	•			
	areas of the hosp				
	(ii) Maintaining a service organizat	•			
	(iii) Maintaining c				
	descriptions with	•			
	responsibilities fo				
	positions.				

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 13 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			00	COMPLETED	
1500		150021	B. W	ING		04/13/	/2016
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	procedure, and ferequirements. (v) Establishing the nursing care and settings in which is provided in the horizontal based on documenterview, the nursing repositioning every patients scoring risk for skin issurpatients #5, #6, and ensure that nursing facility policies (vital signs) documenters with a surgical patients. Findings Included 1. Review of the and Prevention of policy number, I indicated the Brutilized to assess patients. A. On page 5, to 18 is Mild Rishave a "Care plate Pressure Ulcer 1 staff to "Reposit hours if unable to the setting of the staff to "Reposit hours if unable to the setting of the set	nnual in-service established by cal staff policy and deral and state le standards of practice in all hursing care is espital. lent review and arsing supervisor failed to fing staff documented ery 2 hours, for those as a moderate or high les, for 3 of 10 patients, and #10; and failed to fing staff followed the related to post op VS umentation for 2 of 3 and 9. Example 18 possible skin Assessment of Pressure Ulcers, no last approved on 4/13, aden scoring tool is a possible skin issues for sit reads that a score of 15 sk and the patient is to last. Mild Risk for 5 - 18" with the nursing ion minimally every 2	S 09	912	1. Describe what the facility d correct the deficient practice for client cited in the deficiency. Response: The staff on the u where the deficiency occurred receive education regarding the policy expectations (documenturns every 2 hours for patienturns every 2 hours for every 2 hours for patienturns ever	each nits d will he sting ts risk e aily gs, lity ht nts rho	09/01/2016

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 14 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
150021		150021	B. W	·		04/13/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					PARKVIEW PLAZA DRIVE		
DV DK//I	EW REGIONAL ME	DICAL CENTER			VAYNE, IN 46845		
FARRVII	- VV REGIONAL IVIE	DICAL CENTER		FORT	WATNE, IN 40045		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	,	DATE
	•	rate Risk, the patient is to			made or will make to ensure the		
	be "Reposition	ned minimally every 2			the deficient practice does not		
	hours if unable t	o turn self".			recur , including any in-service but this also should include an		
	C. On page 7,	it reads that for scores of			system changes you made.	y	
		sk, the patient is to be			Response:		
	_	minimally every 2 hours			a. Nurse leads will condu	ct 2	
	if unable to turn				audits per shift (4 total for eac		
	ii uiiavie to tulii	SCII			calendar day). Audits will cont		
	1 2 D	41			until 90% compliance is attained	ed	
	_	tient medical records			for 3 consecutive months. b. System-wide review to		
	indicated:				identify and close any gaps.		
	A. Pt. #5 scor	red 14 (Moderate Risk)			4. Describe how the correct	ive	
	on the Braden to	ool on admission 3/15/16.			action(s) will be monitored to		
	It was also noted	d on:			ensure the deficient practice w	/ill	
	a. 3/15/16 at 2	2200 hours that the			not recur, i.e., what quality		
	patient "turns se				assurance program will be put		
		0018 hours that the			into place.		
					Response: Parkview Health Chief Nurs	ina	
	-	lrest" and needed "mod			Executive will be responsible f	-	
	assist".				implementing the education ar		
		ked documentation for			audits.The system by which th		
		om 0800 hours to 1252			responsible person(s) will mor	nitor	
	hours and from	1400 hours to 2051			 Nurse leads will conduct 		
	hours.				audits per shift (4 total for each		
	d. 3/17/16 fro	m 0200 hours to 0710			calendar day). Audits will cont		
	hours lacked doo	cumentation of			until 90% compliance is attained for 3 consecutive months.	ea	
	repositioning.				· Unit education will begin	,	
	repositioning.				May 10, 2016 and will be		
	B. Pt. #6 scored 12 (High Risk) on admission (3/15/16) according to the Braden scoring tool and later scored 12, 11, 10 and 8. Other documentation included: a. On the med/surg nursing unit on 3/15/16 from 1819 hours to 0047 on				completed by June 01, 2016.	Unit	
					audits will begin June 01, 2016		
					until 3 consecutive months of		
					90% compliance is attained.		
	3/15/16 from 18	19 hours to 0047 on					

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 15 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150021		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/13/2016				
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845					
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	to 0421 and 042 b. On 3/16/16, care unit), there repositioning no and 1200 hours: 1500 hours c. On 3/17/16, repositioning ev 0600 hours and 0 C. Pt. #10 was on 4/11/16 with of 15 (Mild Risk being 14 and 15. a. On 4/12/16 documentation b 0600 hours; from hours; and from hours b. Lacked rep from 2300 on 4/ 4/13/16, and lack after 0612 hours review at 1206 b 3. At 3:10 PM of on 4/13/16, inter #50 and #55, qui specialists, confi for patients #5, # documentation e policy and care p	a 68 year old admitted a Braden score initially a) with other assessments a, lacked repositioning between 0100 hours and in 0900 hours to 1600 1600 hours to 2300 cositioning documentation 12/16 to 0612 on ked documentation made to the time of record fours. On 4/12/16 and 11:15 AM review with staff members ality and accreditation irmed that documentation #6 and #10 lacked every two hours, per						

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150021		, ,	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/13 /	ETED	
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	policy number, I indicated on page to be taken at "A (sic), then every 5. Review of the patient #3 indicated the PACU (post 1149 hours on 1 at 1150 hours, I hours with no fur code blue was in 6. Review of the StandardsAdv ICU (intensive of Standards, no number approval, indicating the critical or to have document warming device Admission; Vitaminutes x 5, then (sic), then hourly 7. Review of the patient #8 indicated critical/intensive on 4/12/16 at 18	e policy Clinical re Perioperative, no ast approved on 6/2015, e 6: "Vital Signs" were admit/every 5 min x5 15 min". e medical record for ated the patient arrived in anesthesia care unit) at /22/16 and had VS taken 155 hours and 1200 rther VS noted until a atitiated at 1214 hours. e document Critical Care anced Post-Operative are unit) Patient Care amber or date of ted patients who recover intensive care units are intation for: "Document and temperature on ls on Admit then every 5 in every 15 minutes x7					

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 17 of 18

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

PRINTED: 05/17/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/13/2016	
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER				11109 F	ADDRESS, CITY, STATE, ZIP CODE PARKVIEW PLAZA DRIVE VAYNE, IN 46845		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		E NATE	(X5) COMPLETION DATE
	· · · · · · · · · · · · · · · · · · ·	45 hours, 1900 hours, 30 hours and 1945 hours.					
	with staff mem accreditation sp the post op VS	M on 4/13/16, interview ber #55, a quality and pecialist, confirmed that for patients #3 and #8 5 minutes x 5 as per and protocols.					

State Form Event ID: 2F3511 Facility ID: 005020 If continuation sheet Page 18 of 18