PRINTED: 12/02/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150021	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/26/2022		
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
S 0000							
Bldg. 00	This visit was for the investigation of one state licensure complaint. Complaint Number: IN00320986 Substantiated: Deficiency related to the allegations is cited. Date of survey: 9/26/22 Facility number: 005020 QA: 9/30/2022 IDR Committee met on 11/14/2022. Tag S0930		S 0000				
S 0930 Bldg. 00	modified. 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the Registered Nurse failed to ensure a patient was assisted with repositioning/turning every two hours per physician order for 1 of 5 medical records (MR) reviewed (Patient #1) and failed to ensure skin reassessments were completed every eight hours per facility policy for 1 of 5 medical records reviewed (Patient #1). Findings include:		S 0930	Citation #1 - Based on docume review and interview, the Registered Nurse failed to en a patient was assisted with repositioning/turning every two hours per physician order for medical records (MR) reviews (Patient #1) 1- How are you going to correct the deficiency? If already	sure o 1 of 5 ed		

Sarah Nitza

Accreditation Data Coordinator

12/02/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		150021	B. WI	B. WING		09/26/2022	
				CTD FFT A	ADDRESS STEW STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
PARKVIEW REGIONAL MEDICAL CENTER					PARKVIEW PLAZA DRIVE		
PARKVIE	W REGIONAL ME	DICAL CENTER		FORTV	VAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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'	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					corrected, include the steps ta	ken	
	 Facility policy ti 	itled "Nursing Assessment and			and the date of correction.		
	reassessment - Adn	nitted Patients" last			Education was provided to nur	rsing	
	reviewed/revised or	n 6/2017 indicated the			staff that skin assessment nee	eds	
	following: "B. Re	eassessment2. Reassessments			to be completed and documented		
	will be completed e	every 8 hours at a minimum"			in the electronic medical record		
					every 8 hours per policy.		
		itled "Skin Assessment and			2- How are you going to prevent		
		ure Injuries" last approved on			the deficiency from recurring in the		
		e following: "I. POLICY			future?		
		e incidents of pressure injuries			Unit to complete 30 audits pe	r	
	will be reduced, and when possible, eliminated (as				month on every 8 hour skin		
	a potential patient outcome) by implementing				assessment documentation. Goal		
	routine skin assessmentsand nursing actions to				of 90% or greater for 3 consecutive		
	protect skinII. DEFINITIONS OF TERMSA.				months. Once goal is reached		
	Pressure Injury: "localized injury to the skin				ongoing monitoring to include		
	and/or underlying tissue usually over a bony				audits per month with a goal o		
	prominence, as a result of pressure, or pressure in				consecutive months with 90%	or	
	combination with shear"III. PROCEDURE1.				greater compliance.		
		ll include inspection of bony			3- Who is going to be responsible		
	_	will be assessed for pressure			for numbers 1 and 2 above, (i.	e.	
	-	ess, irritation, swelling,			director, supervisor, etc.)?		
	bruises, irruptions, excoriations, maceration, or				Nursing Manager and Nursing		
		conditions2a. Wound Care			Director		
	Consultmay be initiated by nurses for skin				4- By what date are you going to		
	integrity issues at any time. 3. Skin assessment				have the deficiency corrected?		
	and any alteration in skin integrity will be				11/1/2022		
	documented in the Electronic Medical Record.						
					Citation #2 - Based on docum	ent	
	3. Review of patient #1's medical record indicated				review and interview, the		
	the following:		Registered Nurse failed to ensure				
	(A) The patient was admitted on 12/23/19 for			skin reassessments were			
	surgery and discharged on 12/30/19 at 5:18 p.m.			completed every eight hours per			
	The patient had diagnoses that included but were				facility policy for 1 of 5 medical		
	not limited to gangrene of toes on right foot, right				records reviewed (Patient #1).		
	below knee amputation, end stage renal disease				1- How are you going to correct	Cī	
	on hemodialysis, peripheral vascular disease, and				the deficiency? If already		
	coronary artery disease.				corrected, include the steps ta	ken	
	(D) A -1 · ·	d.,, d., 4. 12/24/10 4. 0. 14			and the date of correction.		
	(B) A physician order dated 12/24/19 at 8:14 p.m.				Staff provided education on		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150021		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2022		
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845				
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	indicated to turn the start on 12/24/19 at on 12/30/19 at 7:24 (C) The medical repatient repositioning and/or patient refuse every two hours for (a.) On 12/25/19 at p.m. (b.) The patient was supine position on p.m., 2:45 p.m., 4:2 (c.) On 12/26/19 at (d.) On 12/27/19 at (e.) On 12/28/19 at (f.) On 12/30/19 at (D) Skin assessment indicated the follow (right) arm, R leg Turgor: Epidermist tissue (Loose)Skin bruisingSkin 3: Refuse (Loose)Skin assessments patient refusing of every eight hours. The skin assessment on the following data (a.) On 12/24/19 at (a.) On 12/24/19 at (b.)	e patient every two hours to a 10:00 p.m. and discontinued b p.m. ecord lacked documentation of ag/turning every two hours bing repositioning/turning at the following dates and times: t 8:00 a.m., 10:00 a.m. and 10:50 as documented as being in the 12/25/19 at 11:40 a.m., 1:25 as p.m. and 6:55 p.m. at 10:00 a.m. and 4:30 p.m. at 12:25 p.m. at 5:00 a.m. and 12:30 p.m. at 5:00 a.m. and 12:30 p.m. at dated 12/24/19 at 6:47 a.m. and the series of subcutaneous and 2: Right Arm-generalized bight Leg-Surgical incisionSkin and skin reassessments of coccyx and/or skin reassessments of coccyx and/or skin reassessments of coccyx and the coccyx was completed at the coccyx was completed at the coccyx was completed at the coccyx and the coccyx and the coccyx was completed at the coccyx and the coccyx and the coccyx was completed at the coccyx and the coccyx was completed at the coccyx and the coccyx and the coccyx was completed at the coccyx and the c			10/7/22 to pull back Mepilex dressing assess skin and document assessment in med record. 2- How are you going to preve the deficiency from recurring in future? Unit to complete 10 audits per month on assessing skin under mepilex and every 2 hour turn Goal of 90% or greater for 3 consecutive months. Once go reached, ongoing monitoring trace include 10 audits per month with goal of 3 consecutive months 90% or greater compliance. 3- Who is going to be respons for numbers 1 and 2 above, (i. director, supervisor, etc.)? Nursing Manager and Nursing Director 4- By what date are you going have the deficiency corrected? 11/1/2022	ent en the er s. al is o ith a with ible e.	

State Form Event ID: PDTE11 Facility ID: 005020 If continuation sheet Page 3 of 5

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150021			A. BUILDING B. WING	00	COMPLE S 09/26/2	ETED	
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845				
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	(F) Skin assessment by Wound Care Nurse dated 12/27/19 at 3:30 p.m. indicated the following:						
	deep tissue injury First Assessed: 12/2 on Hospital Admiss Type: Pressure Injury Descriptiondeep to Purple. Peri-wound Intact. Wound Leng Wound Width9.5 cmWound Surface centimeters]47.5 DTPI [Deep Tissue (b.) "Wound 12/2" unstageableDate It Assessed 12/27/19 Hospital Admission Pressure Injury. Loc Descriptionunstag Slough present. Peri	7/19 Pressure Injury Coccyx First Assessed/Time First .[at][3:40 p.m.]Present on .: No. Primary Wound Type: cation: Coccyx. Wound geableSite Assessment: i-wound Assessment: Purple.): 0.8 cm. Wound Width (cm):					
	cm^2Wound Surfi Injury Stage: U (unstance) (c.) Wound care co wounds. Patient admassessment 12/24/19 wound consult enter right lower leg on 1 nurse presentpaties sacrum/coccyx prior has large purple dee 9.5 cm with small of measures 0.8 x 0.5 cand slough covered,	rface Area (cm^2) 0.4 face Color: PurplePressure stageable) nsult for sacrum and coccyx mitted 12/23/19, skin 9 documented as abrasion, no red. Patient had amputation to 2/23/19. Patient in bed, bedside entstates no open area to r to hospitalization. Sacrum rep tissue injury measuring 5 x pen area to mid coccyx that cm. Coccyx wound is pale pink to unstageable. Mepilex Ag to er with sacral border, change					

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

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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION every 3 days" (G) A review of a nurse note dated 12/27/19 at 3:59 p.m. indicated the following: "Pt [Patient] c/o [complain of] pain to buttocks after dialysis. 2 open areas noted, along with some dark purple discoloration. Wound care consulted" H) A physician order dated 12/27/19 at 4:08 p.m. indicated to peel back foam sacral border dressing for skin assessment to start on 12/28/19 at 6:00 a.m. (I) The medical record lacked documentation of skin reassessments of the patient's sacrum wound and/or patient refusing of skin reassessments of sacrum wound every eight hours for the following dates: 12/28/19, 12/29/19 and 12/30/19. 4. During an interview on 9/26/22 at 4:33 p.m., A6 (Registered Nurse/Nursing Director), he/she verified the medical record information for Patients #1, 2, 3, 4 and 5.								

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