STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155489	A. BUILDING 00 B. WING	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint #IN00201643. Complaint IN00201643 - Substantiated. Federal/State deficiencies related to the allegations are cited at F325. Survey Dates: June 13, 14, 15, 16, 17, 20, 21, and 22, 2016. Facility number: 000419 Provider number: 155489 AIM number: 200901690 Census bed type: SNF/NF: 75 Residential: 8 Total: 83 Census payor type: Medicare: 12 Medicaid: 47 Other: 24 Total: 83 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.	F 0000	This Plan of Correction is prepared and executed because it is required by the provisions of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of July 22, 2016.	

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

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	-3.1. QR completed by 11474 on June 24, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or			

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	roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of blood sugar results in accordance with his orders for 1 of 2 residents reviewed for blood sugar monitoring with physician notification orders. (Resident #65) Findings include: The clinical record for Resident #65 was reviewed on 6/16/16 at 7:25 a.m. Diagnoses for Resident #65 included, but were not limited to, diabetes, delusional disorder, and mild intellectual disabilities. Resident #65's current physician's orders included, but were not limited to, the following: a. Novolog (insulin) inject 5 units subcutaneously two times a day. The original date of this order was 2/12/15. b. Lantus (insulin) inject 26 units subcutaneously once a day. The original	F 0157	1. Resident #65's physician was notified of high blood sugar results from 4/29/16 and on 6/8/16. 2. All diabetic residents have the potential to be affected. The DON completed an audit to ensure physician notification was completed for any blood sugar results outside the residents' MD call parameters. 3. A nursing inservice was to be held on 7/5/16 to review the facility Policy and Procedure on Physician/Family Notification. DON/Designee will review the Vitals Exception Report daily to exclude weekends and holidays to ensure staff compliance. 4. Results of the audits will be reviewed monthly by QA team x 3 months then quarterly x 3. 5. Date of completion: July 22, 2016.	07/22/2016

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	date of this order was 5/15/15. c. Novolog (insulin) inject subcutaneously per sliding scale four times a day- 150 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units 401 and greater = 12 units and call the physician. The original date of this order was 5/4/15. Resident #65 had a current, 5/1/12, revised on 6/15/16, health care plan with a focus of "increased blood sugars." The goal of the health care plan was "My care plan interventions will manage my diabetes." Interventions for the focus included, but were not limited to, "administer insulin as ordered and obtain blood sugars as ordered." Review of the April and June, 2016 Medication Administration Records indicated on 4/29/16, at noon, Resident #65 had a blood sugar result of 423. On 6/8/16, at 5:59 p.m., Resident #65 had a blood sugar result of 401. The nurses notes from 4/29/16 and 6/8/16 lacked any documentation of the physician having been notified of the blood sugar results.			

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	During an interview with the Director of Nursing and the RN Consultant on 6/22/16 at 8:38 a.m., additional information was requested regarding the blood sugar results and physician notification for Resident #65 on 4/29/16 and 6/8/16. During an interview on 6/22/16 at 2:45 p.m., the RN Consultant indicated they were unable to find any documentation of the physician having been notified of Resident #65's blood sugar results on 4/29/16 and 6/8/16. Review of the current, updated 8/2013, facility policy, titled "PHYSICIAN /FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION", provided by the RN Consultant on 6/21/16 at 10:45 a.m., included, but was not limited to, the following: "Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner... ...1. Physician and family/responsible party notification is to include, but is not limited to:.. ...Blood glucose reading below 60 or			

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	greater than 400 unless specific parameters are given by the physician for reporting... ...2. Physician and Family/Responsible [sic] Party [sic] notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained." 3.1-5(a)(3)			
F 0246 SS=E Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure privacy accommodations were in place in a bathroom shared by male and female residents for 1 of 4 co-ed bathrooms reviewed. (Rooms 36 and 37, Residents #65, #33, #117, and #122)	F 0246	1. Facility Maintenance Director installed pin lock doorknobs to the shared bathroom doors between rooms 36 and 37. 2. Residents #65, #33, #117, and #122 all have the potential to be affected. 3. Inservice educating staff on proper use of the pin locks to be held on 7/6/16. Maintenance staff to begin installing this type of	07/22/2016

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	Findings include: During an environmental tour on 6/20/16 at 11:18 a.m., the bathroom shared between Room 36 and 37 was observed with the Maintenance Director. The bathroom door leading to Room 37 from inside the bathroom was observed lacking any type of lock to secure the door. The Maintenance Director indicated a resident inside the bathroom would not be able to lock both bathroom doors to each of the resident rooms to ensure another resident would not enter the bathroom. A "Room listing for Male/Female Residents sharing a bathroom", was provided on 6/22/16 at 11:20 a.m., by the RN Consultant. The document indicated Residents #65, #33, #117, and #122 were capable of entering the bathroom on their own. During an interview on 6/22/16 at 2:45 p.m., the RN Consultant indicated the facility did not have a policy regarding door locks and/or privacy. 3.1-3(v)(1)		doorknob with the pin locks on all bathroom doors that are shared between rooms. 4. Progress/audits will be reviewed for all room moves and admissions involving co-ed restrooms by the QA team monthly x 3 then on an as needed basis. 5. Date of completion: July 22, 2016	
F 0279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS			

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	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop care plans with measurable goals/objectives, for 4 of 17 residents clinical records reviewed for care plans. (Residents #6, #35, #65, and #120) Findings include: 1. The record of Resident #6 was reviewed on 6/16/2016 at 1:33 p.m. Resident #6 had current diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, chronic kidney disease, arterial fibrillation, insomnia, restless leg	F 0279	1. Facility unable to correct for Resident #6 as resident no longer resides at the facility. Resident #35, #65, and #120 each had their care plan goals reviewed and updated to ensure they were measurable. 2. All residents have the potential to be affected. 3. The Regional Director of Quality Assurance presented education on F279 to the IDT team regarding the need to have a goal which can be measured present. MDS/designee is completing an audit of all care plans to ensure there are measurable goals/objectives in place. IDT team will audit the care plans, of those residents who are scheduled for review, weekly during the scheduled care plan	07/22/2016

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	syndrome and gout. Resident #6 had a current, 6/21/2016, physician's order for Lasix (diuretic medication) 40 mg by mouth one time a day. Lantus solution (diabetic medication) inject 32 units subcutaneous at bedtime. Xarelto (anti-coagulant medication) 15 mg by mouth one time a day. Trazodone (anti-depressant medication) 150 mg by mouth one time a day at bedtime. Resident #6 had a current, 6/16/16, care plan problem/need regarding "I have dependant edema in bilateral lower legs." The goal for this problem/need was "my skin will maintain at baseline." Approaches to this problem/need included, but were not limited to, "I will receive diuretics per order" The goals and approaches had no way to measure or determine if they could be met. Resident #6 had a current, 6/16/16, care plan problem/need regarding "I am at risk for my blood sugars to fluctuate related to changes in my normal routine due to diagnosis of diabetes mellitus." The goal for this problem/need was "My blood sugars will stabilize and return to my normal baseline range." Approaches to this problem/need included, but were not limited to, "I will receive insulin as		meetings to ensure there are measurable goals/objectives in place. 4. All audits/findings will be reviewed monthly by QA team x 3 months then quarterly x 3. 5. Date of completion: July 22, 2016	

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	ordered and glucometer checks per order, I will report and you will observe for any changes in my skin integrity and sensation." There was no way to identify if the range was met or what symptoms the resident would display if there were changes. 2. The record of Resident #120 was reviewed on 06/17/2016 8:18 a.m. Resident #120 had current diagnoses which included, but were not limited to, heart failure, end stage renal disease, diabetes mellitus, anxiety disorder, depression disorder, and legal blindness. Resident #120 had a current, 5/27/16, physician's order for alprazolam 1 mg by mouth (anti-anxiety medication) one tablet three times a day, venlafaxine 75 mg by mouth (anti-depressant medication) one time a day, phoslo capsule 667 mg by mouth (kidney replacement medication) 2 tablets before meals. Resident #120 received dialysis three times a week. Resident #120 had a, 6/6/16, 14 day, Minimum Data Set (MDS) assessment which indicated cognitively intact for decision making with consistent/ reasonable statements. Resident #120 had a current care plan			

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	problem/need regarding "I have end stage kidney disease requiring dialysis and am continent of urine." The goal for this problem/need was "my risk of infection will be minimized utilizing my care pan interventions, I will have no complications related to dialysis." There was no identification of what risks or complications might be a problem for the resident. 3. Resident #35's clinical record was reviewed on 6/16/2016 at 10:17 a.m. Resident #35's current diagnoses included, but were not limited to, late-onset cerebella ataxia, diabetes mellitus, mood disorder with depressive features, overactive bladder, and insomnia. Resident #35's current, 4/19/16, physician's orders included, but were not limited to, depakote (anti-epileptic medication), 250 mg by mouth one time a day at bedtime, Celexa (anti-anxiety medication) 40 mg by mouth one time a day, and bupropion (anti-depressant medication) 150 mg by mouth one time a day. Resident #35 had a current, 6/1/16 quarterly, Minimum Data Set (MDS) assessment which indicated the resident was moderately impaired for decision			

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	making, requiring cue/supervision. Resident #35 had a current, 6/16/16, care plan problem/need regarding "I have behavioral symptoms such as obsessive concerns regarding my glasses, eye exams, and insurance. I have also exhibited playing in my feces". The goal for this problem/need was "my behavioral symptom 's will be managed through my care plan interventions." Approaches to this problem/need included, but were not limited to, "approach me in a calm manner. Remind me of appropriate behaviors and proper hygiene." There was no identification of specific triggers for the behaviors or when the interventions might work best. No specific interventions were identified for this resident. The care plan did not identify what obsessive behaviors had been displayed. Resident #35 had a current, 6/16/16, care plan problem/need regarding "I have difficulty sleeping related to diagnosis of insomnia as evidenced by trouble sleeping." The goal for this problem/need was "my care plan interventions will improve my sleeping patterns." Approaches to this problem/need included, but were not limited to,			

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	"encourage me to not consume caffeine and sugary products after evening meal, encourage me from napping through the day." There was no way to measure what was insomnia for this resident and what was a reasonable amount of sleep to feel rested. Resident #35 had a current, 6/6/16, care plan problem/need regarding "I am occasionally incontinent of urine related to: urge and functional incontinence diagnosis of overactive bladder. The goal for this problem/need was "my functional and urge incontinence will be managed through my care plan." Approaches to this problem/need included, but were not limited to, "follow my individualized toilet program: of being toileted early am, after meals, bedtime and upon request, you will assist me with incontinence care and apply barrier cream as needed, assist me with clothing adjustment, cleansing, and transfers during toilet use." 4. The clinical record for Resident #65 was reviewed on 6/16/16 at 7:25 a.m. Diagnoses for Resident #65 included, but were not limited to, diabetes, delusional disorder, and mild intellectual disabilities.			

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	Resident #65's current physician's orders included, but were not limited to, the following: a. Novolog (insulin) inject 5 units subcutaneously two times a day. The original date of this order was 2/12/15. b. Lantus (insulin) inject 26 units subcutaneously once a day. The original date of this order was 5/15/15. c. Novolog (insulin) inject subcutaneously per sliding scale four times a day- 150 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 -350 = 8 units 351 - 400 = 10 units 401 and greater = 12 units and call the physician. The original date of this order was 5/4/15. d. Cymbalta (an anti-depressant often used to treat nerve pain) 30 mg by mouth once a day. The original date of this order was 5/21/14. e. Hydrocodone-acetaminophen (a pain medication) 5-325 mg take one tablet by mouth every 4 hours as needed for pain. Not to exceed 4000 mg of acetaminophen in 24 hours. The original date of this			

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	order was 1/7/13. f. Acetaminophen (a pain medication) 325 mg take two tablets by mouth every 4 hours as need for mild pain and/or a temperature greater than 100 degrees. Not to exceed 4000 mg of acetaminophen in 24 hours. The original date of this order was 6/10/15. An annual Minimum Data Assessment Set (MDS), dated 5/18/16, indicated Resident #65 was cognitively intact. Resident #65 had a current, 4/28/12, and revised on 6/16/15, health care plan for increased blood sugars. The goal of the health care plan was "My care plan interventions will manage my diabetes." There were no measurements in the goal to establish when the resident would be considered to be controlled by the interventions. Resident #65 had a current, 4/28/12, and revised on 6/15/16, health care plan focus for the complaints of pain related to a previous hip fracture immobility, general discomfort, neuropathy, dialysis and headaches. The goal of the health care plan was "Will have my pain relieved with my care plan interventions." There was no way to assess the resident's pain or what would be an acceptable level of			

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	pain. During an interview on 6/22/16 at 1:26 p.m., the Administrator indicated the facility did not fully understand the concept of measurable goals and the need for a method to measure the goals. A current, 1/2012 facility policy, titled "CARE PLANS " was provided by the Director of Nursing on 6/20/16, at 8:43 a.m. It indicated: "Refer to RAI manual chapter 4". Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual indicates a facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the			

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	resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 3.1-35(a)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was transported safely to the shower room for 1 of 3 residents reviewed for accidents. (Resident # 71) Findings include: The clinical record for Resident #71 was reviewed on 6/17/16 at 10:29 a.m. Diagnosis for Resident #71 included, but were not limited to, diabetes, hypertension, and insomnia. A quarterly Minimum Data Assessment Set (MDS), dated 3/12/16, indicated	F 0323	1. One on one education was provided to staff member assisting resident #71 to the shower room. 2. Staff members were interviewed to determine if any residents were being transported to the shower room in a shower chair. 3. Inservice educating staff on facility policy on the proper use of a shower chair held on 7/6/16. DON/designee will perform a weekly audit on various shifts to visualize how residents are being transported to the shower. 4. All audits/findings will be reviewed monthly by QA team x 3 months then quarterly x 3. 5. Date of completion: July 22, 2016.	07/22/2016

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	Resident #71 required the physical assistance of one person to move between locations in his room and adjacent corridor, and to move to and return from distant areas on the floor. Resident #71 had a current, 2/9/15, revised 6/14/16, health care plan focus for falls. An intervention for this focus, dated 6/16/16, indicated "Environmental factors addressed with maintenance adjusting drain caps in hallway to prevent tripping or catching causing falls. Nursing staff educated to avoid crossing over drain caps in center hall when ambulating or propelling residents in wheelchairs." A "Fall IDT [Interdisciplinary Team] Note", dated 6/17/16, indicated Resident #71 was being transported by CNAs in the hallway "in chair when wheel got caught on drain cap , causing chair to jerk and resident to fall out onto floor." The note indicated the resident "sustained abrasions to his forehead, bridge of nose and left knee". A nurses note, dated 6/16/16, indicated Resident #71 "was being pushed in chair down hallway when chair wheel got caught up on drain and carpet. that [sic] made the chair jerk and the resident fell out onto the floor face first...." The note			

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	further indicated Resident #71 "...did hit head. he [sic] has an abrasion on his forehead 1 x 3.2cm [sic] abrasion to bridge of nose 1.4 x 1.7cm [sic] and abrasion to left knee 3.2 x 3.9cm [sic]...." During an interview on 6/17/16 at 10:56 a.m., Resident #71, deemed interviewable during stage one interviews, indicated the "CNA was pushing him down the hall in the shower chair when the shower chair wheel got caught on the drain cap on the floor and I fell out of the shower chair." He indicated he "fell forward and scraped his nose, knee and forehead." During an interview on 6/20/16 at 8:36 a.m., the Maintenance Director indicated he checked each drain cap in the hall to "make sure the caps were flush with the floor." He further indicated there had been some rust build up on the drain cap involved with Resident #71's fall and he had sanded down the drain cap. During an interview on 6/20/16 at 2:05 p.m., the RN Consultant indicated Resident #71 had been in a shower chair at the time of the fall in the hallway on 6/16/16. The RN Consultant provided the in-service information dated 6/16/16. The in-service information indicated "...shower chairs are never used for transporting residents. These chairs are			

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	not safe to be used in this way." The in-service information further indicated "...avoid drain caps in the center of the hallway when transporting residents...." During an interview on 6/21/16 at 9:58 a.m., the RN Consultant indicated the facility did not have a policy or procedure regarding the use of shower chairs to transport residents. She indicated it was not acceptable to use shower chairs in the hallway for transporting residents and staff should not have been using a shower chair to transport Resident #71. During an interview on 6/21/16 at 10:18 a.m., CNA #8 indicated she had worked at the facility for approximately five years. She indicated "you are not supposed to transport a resident in a shower chair." She further indicated "this is nothing new, it has always been that way." During an interview on 6/22/16 at 7:48 a.m., CNA #9 indicated she had worked at the facility for two years. She indicated "we aren't supposed to use shower chairs to transport residents in the hallway." She indicated the recent in-service information "was not new-it has always been that way." 3.1-45(a)(1)			

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	3.1-45(a)(2)			
F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to notify the physician regarding dietary recommendation and/or provide dietary interventions for a nutritionally at risk resident with ongoing weight loss for 1 of 5 residents reviewed for weight loss and nutrition (Residents #K). This deficient practice resulted in Resident #K losing 17.1 pounds within 29 days of admission. Findings include: 1. Resident #K's closed clinical record was reviewed on 6/16/16 at 1:21 p.m. Resident #K's diagnoses included, but were not limited to, unspecified intestinal obstruction, dysphasia, post motor vehicle accident, anxiety disorder and major depressive disorder.	F 0325	1. Facility was unable to correct as resident K no longer resides at this facility. 2. All residents with significant weight loss have the potential to be affected. An audit was completed of all dietician recommendations for the past 30 days to assure that those recommendations had been presented to the physician for review. 3. The Nutrition at Risk team, to include, DON/designee, the Dietician, the Dietary Manager, and the Wound Nurse, will meet the day prior to the Medical Director's weekly visit so recommendations can be presented during that visit. The Director of Nutrition Services inserviced the IDT Nutrition at Risk team members on the Nutrition at Risk policy on 6/30/16 and 7/6/16. Regional Director of Quality Assurance educated IDT Nutrition at Risk team members	07/22/2016

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	Resident #K was readmitted to the facility on 4/4/16. Resident #K's 4/4/16, admission weight was 119.7 lbs. Resident #K had a 4/4/16, admission order for Ensure (a high protein and high calorie supplement) 2 times daily. Resident #K had a current, 4/12/16, care plan problem/need which indicated "I am at risk for malnutrition, I have a hx [history] of periods of nausea which is normal for me. I receive oral supplements." This care plan problem was created 6/5/15, during a previous stay at this long term care facility. The goal to this problem was "My weight will maintain 115-125# [pounds]." Approaches to this problem originated on 6/5/15 and were never revised during her stay in the facility. Approaches to this problem included, but were not limited to, "I will receive my supplements as recommended and Monitor intakes, weights, labs, skin condition reports." A review of Resident #K's weight record for 4/4/16 to 5/2/16, included but was not limited to, the following: 4/4/16, admission weight 119.7 lbs. 4/10/16, weight 112.8 lbs, which was a weight loss of 6.9 lbs in one week. This		on the implementation of the Nutritional Supplements-PCC Guideline Protocol on 6/30/16. The DON/Designee, along with the Dietary Manager/designee, will meet the day after the Medical Director's visit to audit recommendations against orders and documentation. All current residents with significant weight loss are reviewed by the Nutrition at Risk team weekly. An audit of interventions will be completed weekly for four weeks, then monthly for 5 months. The record of this Nutrition at Risk team meeting will be the use of the charting template titled "Dietary-Nutrition at Risk" progress note. The DM will create a summary of each resident discussed. Orders will be obtained for all food, beverage, and supplements that are being used for calorie/protein intervention so that these items appear in the computer system for documentation of acceptance. 4. Results of the audits will be forwarded to the QA team monthly x 3, then quarterly thereafter. 5. Date of Completion: July 22, 2016	

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	was a weight loss of greater than 5%. 4/14/16, weight 107.6 lbs, which was a weight loss of 12.1 lbs in the 10 days following admission. This was a weight loss of 10%. 4/19/16, weight 106.2 lbs, which was a weight loss of 13.5 lbs in the 15 days following admission. This was a weight loss of greater than 10%. 4/27/16, weight 104 lbs, which was a weight loss of 15.7 lbs in the 23 days following admission. This was a weight loss of approximately 13%. 5/2/16, weight 102.6 lbs, which was a weight loss of 17.1 lbs in the 29 days following admission. This was a weight loss of approximately 14%. Resident #K's clinical record included, but was not limited to, the following "Resident Progress Notes" related to complaints of nausea and/or poor appetite: 4/18/16, 5:13 p.m., note indicated an as needed medication was given for nausea and vomiting. The medication was effective. 4/22/16, 1:56 p.m., note indicated an as			

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	needed medication was given for nausea and vomiting. The medication was effective. 4/26/16, 10:36 a.m., note indicated complained of nausea when first awakened. 4/28/16, 11:01 a.m., note indicated the resident continued to have complaints of nausea and vomiting with low meal intake. 4/30/16, 1:50 p.m., note indicated complained of nausea with no appetite. 5/1/16, 9:54 a.m., late entry note indicated the resident continued to feel nauseous and have poor appetite. 5/2/16, 10:36 a.m., note indicated the resident continued to have complaints of nausea. The resident continued to have a poor appetite. The clinical record indicated the doctor was notified of Resident #K's weight loss and/or nausea on the following dates and times: a. 4/12/16, 2:39 p.m., "Resident has had a 9.9% weight loss in 20 days per RD [Registered Dietitian]. [Doctor's name] and family notified." No dietary			

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	intervention to increase caloric intake was initiated at this time. b. 4/18/16, 7:42 a.m., "Resident shows 4.8 pound weight loss in one day. Re-weighed. [Doctor's name] and family notified." No dietary intervention to increase caloric intake was initiated at this time. c. 4/19/16, 2:25 p.m., "Resident has had 9.9% weight loss in 20 days per RD. [Doctor's name] and family notified." No dietary intervention to increase caloric intake was initiated at this time. d. 4/22/16, 1:50 p.m., The doctor was in the facility and decreased Resident #K's pain medication and gave a new order for "Reglan 5 mg (a medication used to treat heartburn and stomach upset) before meals and at bedtime." No dietary intervention to increase caloric intake was initiated at this time. e. 4/26/16, 2:33 p.m., "Resident has had a 14.9% weight loss in 34 days, 10.9% weight loss in 3 weeks, and a 0.6 lb weight loss in 1 week per RD. [Doctor's name] and family notified." No dietary intervention to increase caloric intake was initiated at this time. f. 4/28/16, 11:10 a.m., "resident continue			

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	(sic) to have nausea and vomiting, low intake on meals. [Doctor's name] aware, and social services to do mood assessment." No dietary intervention to increase caloric intake was initiated at this time. g. 4/29/16, 2:16 p.m.," [Doctor's name] here. Based on score of depression scale completed by social services, received new orders for prozac 10mg daily. Pharmacy and family notified." No dietary intervention to increase caloric intake was initiated at this time. Resident #K's "Nutritional Supplement" consumption record for 4/4/16 to 5/2/16 indicated the resident consumed 75% or more of her supplement (Ensure) 41 of 50 times when her supplement was documented as offered. The record indicated Resident #K received her first Ensure supplement on 4/5/16. The record indicated Resident #K was offered ensure no more than 2 times daily during her entire stay in the facility. Resident #K's "Meal Consumption" records for 4/4/16 to 5/2/16 indicated: a. The resident consumed 0-25% of her food 36 of 83 of the documented meals. b. The resident consumed 26-50% of her meals 11 of 83 times meals were offered. c. The resident refused 11 of 83			

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	documented meals. d. This resulted in 61 of 83 documented meals with a consumption of 50% or less. Resident #K had a 4/19/16, "Dietary Progress Note" which indicated "...10.5% weight loss in 27 days...last week had a KUB [test to ensure no blockage in the digestive system] to rule out further small bowel blockage...recommended increasing Ensure frequency...will talk about accepting [brand name] yogurt." author Regional Dietitian. The clinical record lacked any documentation regarding the physician being notified of the 4/19/16, dietary recommendation to increase Ensure. Ensure was never increased during the residents stay in the facility. Yogurt was added to the tray card for breakfast with no indication of the date added. A physician's order was not required to add yogurt to Resident #K's diet. The resident's record lacked any location for the specific consumption of the added yogurt. The yogurt consumption was calculated into total breakfast consumption. There was no method to determine if the yogurt was a successful intervention. Resident #K had a 5/2/16, "Late Entry - Dietary Progress Note" which indicated			

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	the resident had a 14.3% weight loss within 28 days of admission. The resident had nausea and vomiting and was sent to the hospital and admitted on this date. During a 6/22/16, 9:16 a.m., interview, the Dietary Manager indicated the nursing department contacted the resident's physician following the Nutritionally at Risk (NAR) committee meeting and informed the doctor of the committee's concerns and recommendations. She indicated the committee consisted of the Dietary Manager, Wound Nurse, Director of Nursing (DON) and usually another facility nurse. She additionally indicated she added yogurt to Resident #K's meal card and did not document when. She indicated she did not realize adding yogurt to the dietary meal card would not develop a place to document the yogurt's specific consumption. During a 6/22/16, 9:07 a.m., interview, the North Hall RN Unit Manager indicated the nursing department, usually the Unit Manager, would notify the resident's physician if a resident had weight loss or a pattern of poor consumption. She indicated as a rule she notified the doctor for a 2 lb weight change in a day and a 5 lb weight change			

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	in a week. A 5/2/16, 5:07 p.m., Hospital Nursing-Assessment indicated Resident #K had nausea for "a long time." A 5/3/16, 3:04 p.m., hospital "Nutrition Suggestions" indicated Resident #K had admitted with complaints of nausea. The resident was receiving "Ensure Complete" during her past admission and it would be ordered again at this admission for "additional calories and protein." The resident's weight on 5/3/16 was 115.7 lbs. A 5/4/16, 3:38 p.m., Hospital Nutrition Note indicated Resident #K had a primary nutritional diagnosis of "Involuntary Weight Loss. Pt [patient] is on clear liquid diet with poor intake. Pt receiving Ensure Elive and states that she likes them; she is drinking most of it..." Resident #K's weight was 115.7 lbs on 5/3/16 and 121.9 lbs on 5/5/16. A 5/9/16, Hospital Discharge Note indicated Resident #K was admitted to the hospital on 5/2/16 and had the following discharge diagnoses "1. Sepsis secondary to urinary tract infection, secondary to indwelling Foley catheter. 2. Dehydration with acute renal failure. 3. Atherosclerotic heart disease. 4.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hypertension." During her stay, the resident was treated with antibiotics and IV fluids. A current, 12/2014, policy titled "WEIGHTS", provided by the RN Consultant on 6/21/16 at 10:45 a.m., indicated the following: "Policy: In order to ensure effectiveness of interventions and evaluate changes if necessary, residents will be weighed monthly and/or weekly... 9. Dietary recommendations will be acted upon in a timely manner...13. The Registered Dietitian Consultant will assess all significant weight changes at their next scheduled visit and make recommendations for interventions." This federal tag relates to Complaint IN00201643. 3.1-46(a)(1)			
R 0000 Bldg. 00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155489	A. BUILDING 00 B. WING	06/22/2016

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	This visit was for a State Residential Licensure Survey. Residential Census: 8 Sample: 7 Parker Health Care and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. QR completed by 11474 on June 24, 2016.	R 0000	This Plan of Correction is prepared and executed because it is required by the provisions of state and federal law, and not because Parker Health Care agrees with the allegations contained there in. Parker Health Care maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of July 22, 2016.	