STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. BUILDING 00 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW CARE CENTER	2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00411591. Complaint: IN00411591-No deficiencies are cited related to allegations. Survey dates: June 19, 20, 21, 22, 24, 26, 2023 Facility number: 000239 Provider number: 155348 AIM number: 100290150 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 0 Medicaid: 48 Other: 16 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2023.	F 0000	July 20, 2023 Brenda Buroker Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Parkview Care Center Annual Survey ID 2XGX11 Dear Ms. Buroker; On June 26, 2023 a Recertification and State Licensure with Complaint Survey was conducted at our facility. By submitting the enclosed material, Parkview Care Center nor it's management company are not admitting the truth or accuracy of any specific findings or allegations. Parkview Care Center reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective July 20, 2023 to the State findings of the Recertification and State	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Adams		07/20/2023

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			Licensure and Complaint Survey conducted on June 26, 2023. Parkview Care Center respectfully requests a desk review. Please feel free to contact the facility if any additional information is needed. Respectfully submitted, Krista Adams, B.S.N., R.N. HFA Executive Director Parkview Care Center	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure a quarterly assessment Minimum Data Set (MDS) assessment was completed timely for 3 of 16 residents reviewed. (Residents 60, Resident 22, Resident 3) Findings include: 1. Resident 60's record was reviewed on 6/20/23 at 1:29 P.M. The resident was admitted on 2/21/23. The admission MDS assessment was dated 2/28/23 as completed. The clinical record lacked a	F 0638	This Plan of Correction is to serve as Parkview Care Center's credible allegation of compliance. By submitting the enclosed materials, Parkview Care Center nor it's management company are not admitting the truth or accuracy of any specific findings or allegations. Parkview Care Center reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	07/20/2023

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	completed MDS assessment following that date. 2. On 6/22/23 at 8:14 A.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 1/13/23. The most recent completed quarterly MDS (Minimum Data Set) assessment was dated 3/3/23. The clinical record lacked a completed MDS assessment after that date. During an interview on 06/26/23 at 10:20 A.M., the MDS Coordinator indicated that quarterly MDS assessments were due every 90 days. He further indicated that the facility was behind on getting MDS assessments completed and submitted. 3. On 6/26/23 at 10:03 A.M., Resident 3's clinical records were reviewed. The resident was admitted to the facility on 11/2/13. The most recent completed Minimum Data Set (MDS) assessment was dated 2/24/23. A quarterly MDS assessment was started on 5/24/23 but was not completed. The 5/24/23 MDS remained uncompleted and labeled as "in progress", as of 6/26/23. On 6/22/23 at 11:51 A.M., the MDS Coordinator indicated there was no facility policy for entering information into the MDS, and that the RAI (Resident Assessment Indicator) was used for entering information accurately. 3.1-31(d)(3)		regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective July 20, 2023 to the state findings of the Recertification and State Licensure conducted on June 26, 2023. Parkview Care Center respectfully requests a desk review. F – 638 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the MDS coordinator completed and submitted a MDS ARD 5/28/23 for Resident 60, MDS ARD 6/5/23 for Resident 22, MDS ARD 5/24/23 for Resident 3. No resident experienced a negative outcome due to untimely MDS assessment completion and submission. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this alleged deficient practice. The MDS coordinator has reviewed the date of all current in house resident's last completed and submitted MDS assessments to ensure an OBRA MDS for each resident has been submitted and accepted within 92 days. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a mandatory in-service has been	

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			conducted by the Executive Director for the MDS coordinator on the RAI manual related to the timeliness of MDS assessments. The in-service focused on completing and submitting an OBRA MDS assessment for each resident at least every 92 days. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented that monitors the timeliness of OBRA MDS assessments. The tool will monitor to ensure 6 random residents have an OBRA MDS assessment at least every 92 days. This tool will be completed by the MDS Coordinator weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's monthly Quality Assurance meetings for three months then quarterly for 3 quarters to determine if any additional action is warranted.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure MDS (minimum data set) Assessments were accurate for 2 of 6 residents reviewed for unnecessary medications, 1 of 2 residents reviewed for dental, and 1 of 1	F 0641	F - 641 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the MDS coordinator	07/20/2023

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	residents reviewed for pressure ulcers. (Resident 1, Resident 18, Resident 58, Resident 62) Findings include: 1. On 6/20/23 at 1:44 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety, depression, bipolar disorder, and psychotic disorder. The most recent quarterly MDS Assessment, dated 5/12/23, indicated no cognitive impairment. The MDS assessment indicated Resident 1 had not received an anticoagulant, diuretics, or opioids during the 7 day look back period. Current physician orders included, but were not limited to, the following: Fentanyl Patch (an opioid) 75mcg/hour (micrograms per hour) every 72 hours for pain, dated 2/18/23. furosemide (a diuretic) 40mg daily, dated 12/12/22. rivaroxaban (an anticoagulant) 20mg daily, dated 12/12/22. Resident 1's MAR (medication administration record) for May 2023 indicated the following medications were given during the most recent MDS look back period from 5/6/23 through 5/12/23: rivaroxaban (given on 5/6/23) furosemide (given daily from 5/6/23 through 5/12/23) Fentanyl Patch (applied on 5/7/23 and 5/10/23) On 6/22/23 at 2:50 P.M., the MDS Coordinator indicated Resident 1's most recent MDS should have been marked for receiving an anticoagulant, a diuretic and an opioid, and was not entered in		modified and completed Resident 1's MDS ARD 5/11/23, Resident 18's MDS ARD 5/10/23, Resident 62's MDS ARD 5/17/23, Resident 58's MDS ARD 5/10/23. No resident experienced a negative outcome due to untimely MDS assessment completion and submission. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. A housewide audit has been completed by the MDS coordinator on all in house residents most recent MDS assessments for accuracy of medications, dental and pressure ulcers with any finding corrected, submitted and accepted. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a mandatory in-service has been conducted by the Executive Director for the MDS coordinator. The in-service focused on ensuring accuracy of MDS assessments according to the RAI guidelines for medications, dental and pressure ulcers and facility policy on certification of accuracy of the MDS. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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	error. 2. On 6/21/23 at 8:23 A.M., Resident 18's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy and anxiety disorder. The most recent quarterly MDS Assessment, dated 5/10/23, indicated a diagnosis of psychotic disorder. On 6/21/23 at 9:42 A.M., the Administrator indicated Resident 18 did not have a diagnoses of psychotic disorder, and the MDS was marked in error. 3. On 6/19/23 at 10:46 A.M., Resident 62 was observed lying in bed. Resident 62 was observed to not have teeth, and at that time indicated she did not have dentures. On 6/20/23 at 1:26 P.M., Resident 62's clinical record was reviewed. Diagnosis included, but were not limited to, depression. The most recent admission MDS Assessment, dated 5/17/23, indicated no dental concerns, and edentulous (no teeth) was not marked. An admission assessment, dated 5/12/23, indicated Resident 62 was edentulous with missing natural teeth. On 6/22/23 at 11:51 A.M., the MDS Coordinator indicated Resident 62's admission MDS should have been marked with "edentulous", and was not marked in error. At that time, he indicated there was not a policy related to entering information into the MDS, but that they use the RAI (resident assessment instrument) Manual for entering information. 4. Resident 58's clinical record was reviewed on 6/21/23 at 1:51 P.M. Diagnoses included but were		developed and implemented that monitors the accuracy of MDS assessments. The tool will monitor 6 random MDS assessments to ensure that each of the resident's MDS assessment is accurate according to the RAI guidelines including medications, dental and pressure ulcers. This tool will be completed by the MDS Coordinator weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's monthly Quality Assurance meetings for three months then quarterly for 3 quarters to determine if any additional action is warranted.	

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	not limited to heart failure, type 2 diabetes mellitus, and pressure ulcer of left buttock, unstagable. The most recent Minimum Data Set (MDS) assessment dated 5/10/23 indicated a stage 3 pressure ulcer. Wound observation tool assessments dated 6/15/23, 6/7/23, 5/30/23, 5/23/23, 5/16/23, 5/8/23, and 4/28/23 indicated the wound was a stage 3. The most recent care plan dated 5/3/23 included the following care plan: The resident has actual unstageable wound to coccyx r/t impaired mobility and hx of DM. During an interview on 06/22/23 at 02:54 P.M., the Director of Nursing (DON) stated the wound was not a stage 3 wound, was unstageable, and has always been unstageable since resident admitted due to the amount of slough in the wound. On 6/22/23 at 11:51 A.M., the MDS Coordinator indicated there was no facility policy for entering information into the MDS, and that the RAI (Resident Assessment Indicator) was used for entering information accurately. 3.1-31(c)(2) 3.1-31(c)(9) 3.1-31(c)(13) 3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure physician orders and care plan interventions were followed for 1 of 1 residents reviewed for activities of daily living, and 1 of 1 residents reviewed for mobility. (Resident 23, Resident 62) Findings include: 1. On 6/19/23 at 9:32 A.M., Resident 23 was observed lying in bed with the right hand drawn up and contracted. No appliance (splint/brace) was observed on the right hand. On 6/21/23 at 9:33 A.M., Resident 23 was observed lying in bed with the right hand drawn up and contracted. No appliance (splint/brace) was observed on the right hand. On 6/20/23 at 1:47 P.M., Resident 23's clinical record was reviewed. Diagnosis included, but were not limited to depression and psychotic disorder. The most recent quarterly MDS Assessment, dated 3/12/23, indicated Resident 23 was cognitively intact, and required extensive assistance of one staff for bed mobility and toileting, and was totally dependent of one staff for bathing. The MDS indicated no restorative services, and no splint or brace assistance. A current physician order for right padded palm guard, on at all times except hand hygiene for contracture management and skin integrity, check skin daily, was dated 2/20/23.	F 0656	F - 656 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the Director of Nursing reviewed and updated Resident 23's ADL care plan and physician orders to accurately reflect the resident's use of a palm guard. *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the interdisciplinary team reviewed and updated Resident 62's ADL care plan to accurately reflect the resident's abilities and needs. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. A housewide audit by the Director of Nursing has been completed on all resident's physician orders and care plans for palm protectors. All palm protector care plans and physician orders have been reviewed and updated. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be	07/20/2023

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	A current contracture of the right hand care plan, initiated 5/25/23, indicated an intervention for right palm guard to protect skin integrity, dated 5/25/23. Resident 23's clinical record lacked refusals to wear the right padded palm guard. On 6/22/23 at 9:14 A.M., CNA (certified nurse aide) 5 was observed to provide a partial bed bath for Resident 23. Resident 23 was not observed to be wearing any type of appliance on the right hand. When completed, CNA 5 left the room without mentioning the adaptive device to Resident 23. At that time, CNA 5 indicated Resident 23 refused to wear the adaptive device for her right hand, but staff should ask the resident about wearing it. CNA 5 re-entered the room, located the padded palm guard on the floor under Resident 23's bedside table, picked it up, and placed it on the bedside table. CNA 5 did not offer to place the guard on Resident 23's right hand. On 6/22/23 at 11:20 A.M., CNA 5 indicated Resident 23 usually did not wear the right padded palm guard, but every once in a while would. She indicated any resident refusals should have been reported to the nurse, but were not documented. 2. On 6/19/23 at 10:45 A.M., Resident 62 was observed lying in bed. The bed was not in the lowest position, and no fall mat was observed on the right side of the bed (the side closest to the door). On 6/20/23 at 9:00 A.M., Resident 62 was observed lying in bed. The bed was in the lowest position, but no fall mat was observed on the right side of the bed.		affected by this deficient practice. A housewide audit by the Director of Nursing has been completed on all resident ADL care plans. All ADL care plans have been reviewed and updated to include but not limited to mobility. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted by the Director of Nursing for all members of the interdisciplinary team on the facility's policy related to the development and implementation of a comprehensive care plan and following physician orders. The in-service focused on ensuring each resident's care plan and physician orders addresses the resident's need for palm protectors and is kept current based on the needs and abilities of each resident. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted by the Director of Nursing for all members of the interdisciplinary team on the facility's policy related to the development and implementation of a comprehensive care plan. The in-service focused on ensuring each resident's ADL care plan addresses the resident's needs and abilities as well as mobility and is kept current based on the	

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	On 6/21/23 at 9:22 A.M., Resident 62 was observed lying in bed. The bed was not in the lowest position, and no fall mat was observed on the right side of the bed. On 6/24/23 at 9:20 A.M., Resident 62 was observed lying in bed. The bed was in the lowest position with the head of the bed flat. No fall mat was observed on the right side of the bed. On 6/20/23 at 1:26 P.M., Resident 62's clinical record was reviewed. Diagnosis included, but were not limited to, depression. The most recent admission MDS Assessment, dated 5/17/23, indicated a moderate cognitive impairment. Resident 62 required limited assistance of two staff with bed mobility, extensive assistance of two staff with transfers and toileting, and was totally dependent of one staff with bathing. Current physician orders included, but were not limited to: Keep head of bed elevated due to shortness of breath while lying flat, dated 5/15/23. A current risk for falls care plan, initiated 5/13/23, included, but were not limited to, the following interventions: low bed, dated 5/17/23 fall mats to both left and right side of bed, dated 5/25/23 On 6/24/23 at 9:37 A.M., CNA 5 was observed to wheel Resident 62 out of the room. At that time, CNA 5 indicated fall mats were required to be on both sides of the bed when Resident 62 was lying in bed, and the bed was supposed to be kept in the lowest position, but was unaware if the head of the bed was supposed to be up or down.		needs and abilities of each resident. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented that monitors the accuracy and completeness of the resident's care plans and physician orders for palm protectors. The tool will monitor 6 random current residents to ensure that each of the resident's current palm protector needs have an appropriate plan of care and physician order in place. This tool will be completed by the Director of Nursing/Designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's monthly Quality Assurance meetings for three months then quarterly for 3 quarters to determine if any additional action is warranted. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented that monitors the accuracy and completeness of the resident's ADL care plans. The tool will monitor 6 random current residents to ensure that each of the resident's current ADL and mobility needs have an appropriate	

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	On 6/22/23 at 10:57 A.M., the Director of Nursing (DON) indicated there was no official policy on following orders or care plans, but it was expected that all staff follow physician orders and care plan interventions. 3.1-35(a)		plan of care in place. This tool will be completed by the Director of Nursing/Designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's monthly Quality Assurance meetings for three months then quarterly for 3 quarters to determine if any additional action is warranted.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.			

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	155348	A. BUILDING 00 B. WING	06/26/2023

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	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure care plan conferences were completed and care plans revised for 2 of 5 residents reviewed for Accidents, 1 of 2 residents reviewed for Care Planning, 1 of 2 residents reviewed for Dental, and 1 of 2 residents reviewed for Respiratory Care. (Resident 1, Resident 22, Resident 34, Resident 51, and Resident 62) Findings include: 1. On 6/20/23 at 9:22 A.M., Resident 34 was observed to be on 4 L (liters) oxygen with humidification via nasal cannula. The date on the tubing was 6/12 and the date on the humidification bottle was 6/19. On 6/20/23 at 2:20 P.M., Resident 34's clinical record was reviewed. Resident 34 was admitted on 4/4/23. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, morbid obesity, congestive heart failure, and dependence on supplemental oxygen. The most recent admission MDS (Minimum Data Set) assessment, dated 5/2/23, indicated Resident 34 was cognitively intact and was on oxygen. Current physician orders lacked an order for oxygen. A current care plan, revised 5/22/23, indicated that Resident 34 had asthma and uses a bipap while sleeping. The care plan lacked oxygen settings.	F 0657	F - 657 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* the interdisciplinary team reviewed and updated Resident 34's oxygen care plans, Resident 51's fall care plans and Resident 62's dental care plans. Resident 22 is no longer in the facility. *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* Resident 1 had a planned care plan conference which was held and documented in the resident record. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. A housewide audit has been conducted of current in house resident's care plans by the interdisciplinary team. All care plans of current in house residents have been reviewed and updated. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice.	07/20/2023

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	During an interview with RN 9 on 06/22/23 at 10:28 A.M., she indicated she was unable to find an order for oxygen. She further indicated that without an order Resident 34's oxygen use could not be appropriately assessed. On 6/26/23 at 10:15 A.M., a current Oxygen Administration policy, revised 10/7/22, was provided and indicated "Oxygen will be administered in accordance with physician orders". 2. On 6/22/23 at 8:14 A.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 3/14/23. Diagnoses included, but were not limited to, mild dementia without behavioral disturbance, osteoarthritis, presence of right artificial hip joint, and history of falling. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 3/3/23, indicated Resident 22 had moderate cognitive impairment, needed extensive assistance of 1 staff for transfers, needed extensive assistance of 2 or more staff for toileting, and had fallen once since the previous assessment. A progress note dated 2/4/2023 indicated Resident 22 sustained an unwitnessed fall without injury. The clinical record lacked an IDT (Interdisciplinary Discipline Team) note and appropriate intervention associated with this fall. A progress note dated 2/26/23 indicated Resident 22 sustained an unwitnessed fall without injury. The clinical record lacked an IDT note and appropriate intervention associated with this fall. A current care plan, revised 4/28/23, indicated the resident was at risk for falls. The care plan lacked revisions between 1/13/23 and 4/17/23.		A housewide audit has been conducted by the Social Services Director of resident's records for documented care conference for current quarter. All current residents have had a care conference documented in the resident record for the current quarter. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a mandatory in-service has been provided by the Director of Nursing for the interdisciplinary team on their responsibility for reviewing and revising as necessary of care plans for each resident in accordance with facility policy. The interdisciplinary team was educated on their responsibility to ensure that each resident's care plan is reviewed and revised as necessary at least quarterly, with any significant change in condition or upon the resident and/or their representative's request. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* the Social Service Director was educated by the Executive Director on their responsibility to document a summary of the care plan conference in the resident's clinical record at least quarterly. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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	3. On 6/22/23 at 12:39 P.M., Resident 51's clinical record was reviewed. Resident 51 was admitted on 10/27/22. Diagnoses included, but were not limited to, Alzheimer's Disease, bilateral hearing loss, and generalized muscle weakness. The most recent quarterly MDS assessment, dated 5/6/23, indicated Resident 51 had severe cognitive impairment, needed extensive assistance of 2 or more staff for transfers, needed extensive assistance of 2 or more staff for toileting, and had fallen 2 or more times since the previous assessment. A progress note dated 1/24/23 indicated Resident 51 sustained an unwitnessed fall without injury. The clinical record lacked an IDT note and appropriate intervention associated with this fall. A progress note dated 2/27/23 indicated Resident 51 sustained an unwitnessed fall without injury. The clinical record lacked an IDT note and appropriate intervention associated with this fall. A current care plan, initiated 10/28/22, indicated the resident was at risk for falls. The care plan lacked revisions between 1/6/23 and 3/28/23. During an interview on 06/26/23 at 08:38 A.M., the DON indicated that she expected the care plan to be updated with an intervention after a fall. She further indicated that it had been difficult for IDT to meet due to staffing changes. 4. On 6/19/23 at 10:20 A.M., Resident 1 indicated a care plan conference had not been completed in "a long time". On 6/20/23 at 1:44 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety, depression, bipolar		developed and implemented to monitor current resident's care plans are being reviewed and revised as necessary at least every quarter by the interdisciplinary team. The tool will monitor 6 random current residents to ensure that each of the resident's current ADL and mobility needs have an appropriate plan of care in place. This tool will be completed by the Director of Nursing/Designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is a* A Quality Assurance tool was developed and implemented to monitor current resident's records to ensure each resident's care conference is being documented in the resident record. This tool will monitor 6 random resident's records by the Social Service Director weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	disorder, and psychotic disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 5/12/23, indicated no cognitive impairment. A progress note, dated 7/22/22, indicated the IDT (Interdisciplinary Team) reviewed resident's plan of care. The power of attorney declined an invitation to the care plan conference. The clinical record lacked documentation that a care plan conference had been scheduled or held since 7/22/22. On 6/22/23 at 10:56 A.M., the Director of Nursing (DON) indicated care plan conferences should be held with the resident and resident's representative quarterly or with a significant change in status. She indicated a formal care plan conference had not been done for Resident 1 because the facility met with with her frequently, and she did not have family to invite. She indicated the IDT team would do a care plan review weekly, but would still expect documentation of an actual care plan conference in the chart. 5. On 6/19/23 at 10:46 A.M., Resident 62 was observed lying in bed. Resident 62 was observed with no teeth. On 6/21/23 at 9:22 A.M., Resident 62 was observed lying in bed. At that time, she was observed with no teeth and indicated she was missing all of her natural teeth and did not wear dentures. On 6/20/23 at 1:26 P.M., Resident 62's clinical record was reviewed. Diagnosis included, but were not limited to, depression. The most recent admission MDS (minimum data set) Assessment,			

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	dated 5/17/23, indicated a moderate cognitive impairment. The MDS did not indicate any dental concerns, and "edentulous" (no teeth) was not marked. Resident 62 had a current diet order for a regular diet, mechanically altered texture, with nectar consistency, dated 5/12/23. The clinical record lacked a care plan related to being edentulous. A nutritional assessment, dated 5/20/23, had nothing checked for dentition or chewing abilities to indicate natural teeth, dentures, or missing teeth. On 6/22/23 at 11:51 A.M., the MDS Coordinator indicated a resident with no teeth should have a care plan related to their dental status. He indicated if there was no care plan for an edentulous resident, he could open up initial care plans through the MDS and go in and modify them. On 6/26/23 at 9:09 A.M., a current Comprehensive Care Plans and Conferences policy, dated 1/26/23, was provided and indicated "the resident's care plan must be...revised based on changing goals, preferences and needs of the resident and in response to current interventions". 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

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	hygiene; Based on observation, interview, and record review, the facility failed to ensure services were provided to maintain personal hygiene for 2 of 3 residents reviewed for activities of daily living. Dependent residents were not provided showers as scheduled or according to preference. (Resident 1, Resident 62) Findings include: 1. On 6/19/23 at 10:18 A.M., Resident 1 indicated her hair was not getting washed because the staff could not accommodate her preference for having her hair washed. She indicated she had requested that staff wash her hair in bed with the water running into a trash can, and was told that could not happen as the trash can would be too heavy for staff to pick up and empty. She indicated she was supposed to be bathed twice a week, and was not getting them that often. On 6/20/23 at 1:44 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety, depression, bipolar disorder, and psychotic disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 5/12/23, indicated no cognitive impairment. Resident 1 required extensive assistance of one staff with bed mobility, and was totally dependent of one staff with bathing. Resident 1's clinical record indicated the following showers/bed baths were given from 5/22/23 through 6/20/23: Thursday 6/8/23 (bed bath) Monday 6/12/23(bed bath) No refusals for bathing were documented during that time period	F 0677	F – 677 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is* Resident 1's bathing preferences were reviewed with resident and updated in care plan and Resident 62's bathing preferences were reviewed with resident and updated in care plan. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. A housewide audit was conducted of current in house resident's shower schedule and completion. Updated shower sheets require resident's signature if resident refuses shower on scheduled day. Activities to now complete a bathing preference sheet upon admission, MDS to update care plans accordingly and DNS to update shower schedules. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a mandatory in-service has been conducted for all nursing staff by the Assistant Director of Nursing on the facility's policies related to bathing. The nursing staff was educated on updated shower sheets requiring any resident who refuses showers to sign. The Activity Director was educated by	07/20/2023

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	On 6/21/23 at 2:40 P.M., shower sheets were provided, with the following for Resident 1 from 5/22/23 through 6/20/23: Monday 5/22/23 (bed bath, nothing marked for washing hair) Monday 5/29/23 (bed bath, hair not washed) Monday 6/12/23 (bed bath, hair washed) Monday 6/19/23 (shower, hair washed) On 6/21/23 at 1:00 P.M., the Director of Nursing (DON) indicated Resident 1 had requested her hair to be washed into a trash can, and staff could not accommodate that because the trash can got too heavy. She indicated Resident 1 would not use the blow up headrest for washing her hair. On 6/21/23 at 10:55 A.M., CNA 7 indicated all showers were documented into the resident's electronic record, and a shower sheet filled out that was signed by a nurse and placed at the nurse's station. At that time, a weekly shower schedule was reviewed at the nurses station that indicated Resident 1's shower days were Monday and Thursday. On 6/22/23 at 11:20 A.M., CNA (certified nurse aide) 5 indicated Resident 1 usually requested a bed bath (about 90% of the time), and did like her hair washed. She indicated Resident 1 did not refuse bathing. 2. On 6/19/23 at 10:46 A.M., Resident 62 was observed lying in bed. Resident 62's hair was greasy and not brushed. On 6/21/23 at 9:22 A.M., Resident 62 was observed lying in bed with greasy hair. On 6/20/23 at 1:26 P.M., Resident 62's clinical record was reviewed. Diagnosis included, but		the Director of Nursing on completing a shower preference form on all newly admitted resident's within 72 hours. *4.) The corrective action taken to monitor to ensure the deficient practice will not recur is* a Quality Assurance tool has been developed and implemented to ensure that each resident is receiving baths according to their preferences. The tool will monitor to ensure that showers are being completed and documented. The tool will also monitor to ensure new residents are submitting their bathing preferences upon admission. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	were not limited to, depression. The most recent admission MDS Assessment, dated 5/17/23, indicated a moderate cognitive impairment. Resident 62 required extensive assistance of two staff with transfers and toileting, and was totally dependent of one staff with bathing. The preferences section of the MDS was not assessed. Resident 62's clinical record lacked a care plan related to preferences for bathing or refusals. Progress notes included, but were not limited to, the following: 6/16/23 9:39 A.M. Resident's urine from 6/15/23 was positive for UTI (urinary tract infection) ... Resident had increased confusion, taking pants off, and sitting on the floor urinating for the past two days ... Resident 62's clinical record indicated the following showers/bed baths were given from 5/22/23 through 6/20/23: Friday 6/2/23 (bed bath) Monday 6/5/23 (refused one time) Tuesday 6/6/23 (refused one time) Friday 6/9/23 (bed bath) Tuesday 6/20/23 (bed bath) On 6/21/23 at 2:40 P.M., shower sheets were provided, with the following for Resident 62 from 5/22/23 through 6/20/23: Saturday 5/27/23 (bed bath, hair washed in beauty salon) Tuesday 5/30/23 (checked between shower and bed bath, no other information) Thursday 6/1/23 (checked between shower and bed bath, hair not washed) Thursday 6/8/23 (checked between shower and bed bath, no other information)			

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	Saturday 6/10/23 (stated had shower already and wasn't taking another) Monday 6/19/23 (checked between shower and bed bath, no other information) Tuesday 6/20/23 (checked between shower and bed bath, no other information) On 6/21/23 at 10:55 A.M., a weekly shower schedule was reviewed at the nurses station that indicated Resident 62's shower days were Wednesday and Saturday. On 6/22/23 at 10:16 A.M., Resident 62's daughter indicated Resident 62 had always preferred showers prior to being admitted to the facility on 5/12/23. She indicated Resident 62 loved to have her hair washed, and had recently paid to have her hair done, but was unsure if it had been done yet or not. On 6/22/23 at 11:55 A.M., a Resident Preference Questionnaire form, dated 5/12/23, was provided and indicated spoke with "daughter ... in person". The form indicated Resident 62 preferred bed baths. The form was not signed by Resident 62's daughter. On 6/22/23 at 11:20 A.M., CNA 5 indicated Resident 62 preferred showers, and had never refused bathing for her. She indicated she would ask the resident what type of bathing she wanted, and 90% of the time, she would tell her a shower. She indicated Resident 62 was excited to get into the shower and will allow staff to wash her hair. CNA 5 indicated if a resident were to refuse bathing, the CNA should notify the nurse, and re-check with the resident three times total and document all refusals on the shower sheets. On 6/21/23 at 2:32 P.M., facility grievances were			

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	reviewed with the following related to showers: 2/2/23 "States that aide told her there was no hot water and she could not get shower. Resident asked for shower next day and was told she's not scheduled for that day" 2/23/23 "Pt (patient) asked therapist if she could get a shower for treatment. Pt stated she has not gotten any showers since she has arrived. Pt stated she asked nursing staff to put her on the shower list" 2/23/23 "Pt complaining of not getting showers. Pt stated she only gets showers when given by therapist ..." 2/27/23 "Resident very upset because she hasn't had her hair washed in over a week" 3/28/23 "Patient complaining of not getting showers. Patient stated she asked for water in a bin and soap and thought it was asking a lot of the staff. Patient so upset she stated she was about to call her POA (power of attorney) to come take her home. Patient states she only gets showers from therapy" On 6/22/23 at 2:37 P.M., a current Activities of Daily Living policy, revised 8/22/22, was provided and indicated "The resident will receive assistance as needed to complete activities of daily living (ADLs) ... A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal oral hygiene" 3.1-38(a)(3)			
F 0732 SS=C	483.35(g)(1)-(4) Posted Nurse Staffing Information			

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Bldg. 00	§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily	F 0732	F - 732 *1.) The corrective action taken for*	07/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. BUILDING 00 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW CARE CENTER	2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720

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	posted nurse staffing reflected the actual hours worked by staff for 3 of 6 days during the survey. Findings include: During an observation on 6/19/23 at 10:30 A.M., the posted daily staffing sheet included the date, census, RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nurse Aide) columns with number present and total hours worked for "days, evenings, and nights". The sheet did not indicate the time frame of the different shifts and lacked actual hours worked by staff. On 6/21/23 at 9:20 A.M., the posted daily staffing sheet lacked actual hours worked by staff. On 6/24/23 at 9:18 A.M., the posted daily staffing sheet lacked actual hours worked by staff. On 6/26/23 at 9:00 A.M., The Director of Nursing and Administrator indicated they were unaware that the posted daily staffing sheets were required to have actual hours indicated on them, and that it was assumed visitors would know what hours "days, evenings, and nights" were. On 6/26/23 at 9:09 A.M., a current Staffing policy, dated 7/27/22, was provided and indicated "The facility must post the following information on a daily basis ... The total number and the actual hours worked ..."		*those residents found to have been affected by the deficient practice is* the Posted Nurse Staffing sheet accurately reflects the time of each shift. No resident was identified as being affected in this statement of deficiencies. The form being utilized was not specific enough and was updated during the survey process on 6/26/2023 when it was brought to the Executive Director's attention. *2.) The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is* all residents have the potential to be affected by this deficient practice. The Executive Director implemented a new form for Posted Nurse Staffing which are now accurate including the actual time of each shift worked by nursing staff. *3.) The measures that have been put into place to ensure that the deficient practice does not recur is* a mandatory in-service has been conducted by the Executive Director for the Director of Nursing and scheduler on the facility's policy related to the completion of the Posting of the Nurse Staffing information. The DNS and scheduler were advised of their responsibility in reviewing the posting at the beginning of each shift to ensure its accuracy and make any changes as warranted. *4.) The corrective action taken to*	

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			monitor to ensure the deficient practice will not recur is a Quality Assurance tool has been developed and implemented to monitor the accuracy of the Posted Nurse Staffing information. This tool will be completed by the Director of Nursing/designee daily for two weeks, then weekly for 2 weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	