	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	A. BUILDING <u>00</u> CC			COMPL	ATE SURVEY DMPLETED 5/26/2023	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Bldg. 00	Licensure Survey. with the Investigati Complaint: IN0041 related to allegation Survey dates: June Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type Medicare: 0 Medicaid: 48 Other: 16 Total: 64 These deficiencies accordance with 41 Quality review com	19, 20, 21, 22, 24, 26, 2023 20239 55348 290150 :: reflect State Findings cited in 0 IAC 16.2-3.1. inpleted on July 5, 2023.	F 00		July 20, 2023 Brenda Buroker Director Division of Long Terr Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Parkview Care Center Annual Survey ID 2XGX Dear Ms. Buroker; On June 26, 2023 a Recertificand State Licensure with Complaint Survey was conduat our facility. By submitting tenclosed material, Parkview Center nor it's management company are not admitting the truth or accuracy of any specifindings or allegations. Parkview Care Center reserves the right contest the findings or allegation of any proceedings are submit these responses pursuabmit these responses	cation cted che Care e fific riew nt to cions nd uant The		
LABORATOR	LY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	į.	TITLE		(X6) DATE	

(X6) DATE

Krista Adams 07/20/2023

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP COD IORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				Licensure and Complaint Sun conducted on June 26, 2023. Parkview Care Center respec requests a desk review.	
				Please feel free to contact the facility if any additional inform is needed.	
				Respectfully submitted,	
				Krista Adams, B.S.N., R.N. H Executive Director Parkview Care Center	IFA
F 0638 SS=D Bldg. 00	§483.20(c) Quarter A facility must assign quarterly review in State and approve frequently than on Based on record revialled to ensure a quarter (MDS) assign for 3 of 16 residents Resident 22, Resident Eindings include: 1. Resident 60's reconstant 1:29 P.M. The resident was add The admission MDS	ord was reviewed on 6/20/23 at	F 0638	This Plan of Correction is to s as Parkview Care Center's credible allegation of complian By submitting the enclosed materials, Parkview Care Cennor it's management company not admitting the truth or accurof any specific findings or allegations. Parkview Care Creserves the right to contest the findings or allegations as part any proceedings and submit tresponses pursuant to our	nce. Iter I are Iracy enter ne of

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155348	B. W	ING		06/26/	2023
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					ORTH ST JOSEPH AVE		
PARKVII	EW CARE CENTER	ζ		EVANS	WILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	completed MDS as	sessment following that date.			regulatory obligations. The fa	cility	
	2. On 6/22/23 at 8:	14 A.M., Resident 22's clinical			requests the plan of correction	ı be	
	record was reviewe	ed. Resident 22 was admitted on			considered our allegation of		
	1/13/23. The most recent completed quarterly				compliance effective July 20,	2023	
	MDS (Minimum Data Set) assessment was dated				to the state findings of the		
	3/3/23. The clinical record lacked a completed				Recertification and State		
	MDS assessment after that date.				Licensure conducted on June	26,	
					2023. Parkview Care Center		
	During an interview on 06/26/23 at 10:20 A.M., the				respectfully requests a desk		
	MDS Coordinator indicated that quarterly MDS				review.		
	assessments were d	lue every 90 days. He further			F – 638		
	indicated that the fa	acility was behind on getting			1.) The corrective action take	n for	
	MDS assessments completed and submitted.				those residents found to have		
	3. On 6/26/23 at 10	0:03 A.M., Resident 3's clinical			been affected by the deficient		
	records were review	wed. The resident was admitted			practice is the MDS coordinate	or	
	to the facility on 11	/2/13. The most recent			completed and submitted a M	DS	
	completed Minimu	m Data Set (MDS) assessment			ARD 5/28/23 for Resident 60,		
	was dated 2/24/23.	A quarterly MDS assessment			MDS ARD 6/5/23 for Resident	t 22 ,	
	was started on 5/24	/23 but was not completed.			MDS ARD 5/24/23 for Reside	nt 3.	
	The 5/24/23 MDS i	remained uncompleted and			No resident experienced a		
	labeled as "in progr	ress", as of 6/26/23.			negative outcome due to untir	nely	
					MDS assessment completion	and	
	On 6/22/23 at 11:5	1 A.M., the MDS Coordinator			submission.		
	indicated there was	no facility policy for entering			2.) The corrective action take	n for	
	information into the	e MDS, and that the RAI			the other residents that have t	he	
	(Resident Assessme	ent Indicator) was used for			potential to be affected by the		
	entering informatio	n accurately.			same deficient practice is all		
					residents have the potential to	be	
	3.1-31(d)(3)				affected by this alleged deficie	∍nt	
					practice. The MDS coordinate	or	
					has reviewed the date of all cu	urrent	
					in house resident's last compl	eted	
					and submitted MDS assessme	ents	
					to ensure an OBRA MDS for e		
					resident has been submitted a	and	
					accepted within 92 days.		
					3.) The measures that have b		
					put into place to ensure that the	ne –	
					deficient practice does not rec	ur is	
					a mandatory in-service has be	en	

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

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE SVILLE, IN 47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
				conducted by the Executive Director for the MDS coordina on the RAI manual related to to timeliness of MDS assessment The in-service focused on completing and submitting an OBRA MDS assessment for e resident at least every 92 days 4.) The corrective action take monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented to monitors the timeliness of OBI MDS assessments. The tool of monitor to ensure 6 random residents have an OBRA MDS assessment at least every 92 days. This tool will be comple by the MDS Coordinator week for four weeks, then monthly for three months and then quarter for three quarters. The outcor 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.	the hts. ach s. n to t en hat RA will sted sly or rly me of ee	
F 0641 SS=E Bldg. 00	The assessment r resident's status. Based on observation review, the facility:	nust accurately reflect the on, interview, and record failed to ensure MDS (minimum	F 0641	F - 641 1.) The corrective action taker		07/20/2023
	· · · · · · · · · · · · · · · · · · ·	ts were accurate for 2 of 6 for unnecessary medications, 1		those residents found to have been affected by the deficient		

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of 2 residents reviewed for dental, and 1 of 1

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practice is the MDS coordinator

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/26/2023	
NAME OF I	PROVIDER OR SUPPLIER	· }		ADDRESS, CITY, STATE, ZIP COD	-
				NORTH ST JOSEPH AVE	
PARKVII	EW CARE CENTER	(EVAN	SVILLE, IN 47720	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		for pressure ulcers. (Resident		modified and completed Residue ARR 5/44/99 Residue	
	1, Resident 18, Resident 58, Resident 62)			1's MDS ARD 5/11/23, Reside	
	Findings include:			18's MDS ARD 5/10/23, Residence 62's MDS ARD 5/17/23, Residence 62's MDS ARD 5/17/23, Residence 62's MDS ARD 5/17/23, Residence 62's MDS ARD 5/10/23, MDS ARD 5/10/23	
				58's MDS ARD 5/10/23. No	ueni
	1. On 6/20/23 at 1:4	14 P.M., Resident 1's clinical		resident experienced a negati	ive
		d. Diagnosis included, but		outcome due to untimely MDS	
		anxiety, depression, bipolar		assessment completion and	
	disorder, and psych	otic disorder. The most recent		submission.	
	quarterly MDS Ass	essment, dated 5/12/23,		2.) The corrective action take	en for
		ive impairment. The MDS		the other residents that have	the
	assessment indicated Resident 1 had not received			potential to be affected by the	•
	an anticoagulant, diuretics, or opioids during the 7			same deficient practice is all	
	day look back period.			residents have the potential to	
				affected by this deficient prac	tice.
		orders included, but were not		A housewide audit has been	
	limited to, the follo	_		completed by the MDS	
		opioid) 75mcg/hour		coordinator on all in house	
		our) every 72 hours for pain,		residents most recent MDS	
	dated 2/18/23.			assessments for accuracy of	NUTO .
	furosemide (a diure	tic) 40mg daily, dated 12/12/22.		medications, dental and press ulcers with any finding correct	
	Turosennae (a uture	12/12/22.		submitted and accepted.	ieu,
	rivaroxaban (an ant	icoagulant) 20mg daily, dated		3.) The measures that have to	been
	12/12/22.	2 ,		put into place to ensure that t	
				deficient practice does not red	
	Resident 1's MAR (medication administration		a mandatory in-service has be	
	record) for May 202	23 indicated the following		conducted by the Executive	
	medications were g	iven during the most recent		Director for the MDS coordina	ator.
	MDS look back per	riod from 5/6/23 through		The in-service focused on en	suring
	5/12/23:			accuracy of MDS assessmen	
	rivaroxaban (given			according to the RAI guideline	
		daily from 5/6/23 through		medications, dental and press	sure
	5/12/23)	1: 1 5/7/22 15/10/22		ulcers and facility policy on	
	Fentanyi Patch (app	blied on 5/7/23 and 5/10/23)		certification of accuracy of the	;
	On 6/22/22 at 2:50	D.M. the MDS Coordinates		MDS.) n to
		P.M., the MDS Coordinator 1's most recent MDS should		4.) The corrective action take	
		for receiving an anticoagulant,		monitor to ensure the deficient practice will not recur is that a	
		oioid, and was not entered in		Quality Assurance tool has be	
	, a ararono una un up	, and mad not circled iii	1	i guanty / toourariot tour rido be	, o i

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155348	B. W.	ING		06/26/2	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			ORTH ST JOSEPH AVE		
PARKVIF	W CARE CENTER	!			VILLE, IN 47720		
	T		1			<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	error.				developed and implemented the		
					monitors the accuracy of MDS	,	
	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,				assessments. The tool will		
					monitor 6 random MDS	.	
					assessments to ensure that ea		
					of the resident's MDS assessr		
	dated 5/10/23, indicated a diagnosis of psychotic				is accurate according to the R		
	disorder.				guidelines including medicatio		
	0. (21/22 + 0.42 + M. d. + 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.				dental and pressure ulcers. T		
	On 6/21/23 at 9:42 A.M., the Administrator indicated Resident 18 did not have a diagnoses of				tool will be completed by the N		
					Coordinator weekly for four we		
	psychotic disorder, and the MDS was marked in				then monthly for three months		
	error.				then quarterly for three quarte		
	2 0 (110/22 110	46 4 16 P 11 + 60			The outcome of this tool will be		
		:46 A.M., Resident 62 was			reviewed at the facility's month	-	
		ed. Resident 62 was observed			Quality Assurance meetings for		
		nd at that time indicated she			three months then quarterly fo	r 3	
	did not have denture	es.			quarters to determine if any		
	0 (/20/22 + 1.26)	DM D '1 (62) 1' ' 1			additional action is warranted.		
		P.M., Resident 62's clinical					
		d. Diagnosis included, but					
		depression. The most recent					
		sessment, dated 5/17/23,					
		concerns, and edentulous (no					
	teeth) was not mark	cu.					
	An admission asses	sment, dated 5/12/23,					
		62 was edentulous with					
	missing natural teet						
	imoonig natural teet	•••					
	On 6/22/23 at 11·51	A.M., the MDS Coordinator					
		62's admission MDS should					
		vith "edentulous", and was not					
		t that time, he indicated there					
		ated to entering information					
	1	hat they use the RAI (resident					
		ent) Manual for entering					
	information.	,uniour for ontorning					
		nical record was reviewed on					
		I. Diagnoses included but were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2023		
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE SVILLE, IN 47720	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION
mo	not limited to heart	failure, type 2 diabetes ure ulcer of left buttock,	me		Bill
		nimum Data Set (MDS) (10/23 indicated a stage 3			
	6/15/23, 6/7/23, 5/3	tool assessments dated 0/23, 5/23/23, 5/16/23, 5/8/23, ed the wound was a stage 3.			
	The most recent car the following care p	re plan dated 5/3/23 included plan:			
		tual unstageable wound to mobility and hx of DM.			
	Director of Nursing not a stage 3 wound always been unstag	on 06/22/23 at 02:54 P.M., the (DON) stated the wound was I, was unstageable, and has eable since resident admitted of slough in the wound.			
	indicated there was information into the	A.M., the MDS Coordinator no facility policy for entering e MDS, and that the RAI ent Indicator) was used for n 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) Comp §483.21(b)(1) The	nt Comprehensive Care Plan rehensive Care Plans a facility must develop and prehensive person-centered			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155348	B. W	NG		06/26	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ORTH ST JOSEPH AVE		
PARKVI	EW CARE CENTER	₹		EVANSVILLE, IN 47720			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	care plan for eacl	h resident, consistent with					
	the resident rights	s set forth at §483.10(c)(2)					
	and §483.10(c)(3), that includes measurable					
	objectives and tin	neframes to meet a					
	resident's medica	al, nursing, and mental and					
	psychosocial nee	ds that are identified in the					
	comprehensive a	ssessment. The					
	comprehensive c	are plan must describe the					
	following -						
	(i) The services that are to be furnished to						
	attain or maintain	the resident's highest					
	practicable physic	cal, mental, and					
	psychosocial well	l-being as required under					
	§483.24, §483.25	5 or §483.40; and					
	(ii) Any services t	hat would otherwise be					
	required under §4	483.24, §483.25 or §483.40					
	but are not provid	led due to the resident's					
	exercise of rights	under §483.10, including					
	the right to refuse	treatment under §483.10(c)					
	(6).						
	(iii) Any specialize	ed services or specialized					
	rehabilitative serv	rices the nursing facility will					
	provide as a resu	llt of PASARR					
	recommendations	s. If a facility disagrees with					
	_	e PASARR, it must indicate					
	its rationale in the	e resident's medical record.					
	` '	n with the resident and the					
	resident's represe	` ,					
	' '	s goals for admission and					
	desired outcomes	= =					
	` '	s preference and potential for					
	_	Facilities must document					
	whether the resid	lent's desire to return to the					
		ssessed and any referrals					
		gencies and/or other					
	appropriate entitie	es, for this purpose.					

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this section.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155348	B. W	ING		06/26/	/2023
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ORTH ST JOSEPH AVE		
PARKVII	EW CARE CENTER	t		EVANS	SVILLE, IN 47720		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	- ' ' ' '	e services provided or acility, as outlined by the					
	comprehensive ca	-					
	(iii) Be culturally-c						
	trauma-informed.						
	Based on observation, interview, and record		F 00	656	F - 656		07/20/2023
	review, the facility failed to ensure physician				1.) The corrective action taken for		
	orders and care plan interventions were followed				those residents found to have		
	for 1 of 1 residents	reviewed for activities of daily			been affected by the deficient		
	_	esidents reviewed for mobility.			practice is the Director of Nurs	sing	
	(Resident 23, Resid	ent 62)			reviewed and updated Reside		
					23's ADL care plan and physic		
	Findings include:				orders to accurately reflect the		
	1. On 6/19/23 at 9:32 A.M., Resident 23 was				resident's use of a palm guard		
		ed with the right hand drawn			1.) The corrective action take those residents found to have		
		No appliance (splint/brace)			been affected by the deficient		
	was observed on the				practice is the interdisciplinary		
	was observed on the	e right hand.			team reviewed and updated		
	On 6/21/23 at 9:33	A.M., Resident 23 was			Resident 62's ADL care plan t	0	
	observed lying in b	ed with the right hand drawn			accurately reflect the resident'		
	up and contracted.	No appliance (splint/brace)			abilities and needs.		
	was observed on the	e right hand.			2.) The corrective action take	n for	
					the other residents that have t	he	
		P.M., Resident 23's clinical			potential to be affected by the		
		d. Diagnosis included, but			same deficient practice is all		
		depression and psychotic			residents have the potential to		
		recent quarterly MDS			affected by this deficient pract		
		3/12/23, indicated Resident 23			A housewide audit by the Dire		
		act, and required extensive aff for bed mobility and			of Nursing has been complete		
		otally dependent of one staff			all resident's physician orders		
	-	DS indicated no restorative			care plans for palm protectors palm protector care plans and		
		int or brace assistance.			physician orders have been		
	Solvieces, und no spi	and of orace application.			reviewed and updated.		
	A current physician	order for right padded palm			2.) The corrective action take	n for	
		es except hand hygiene for			the other residents that have t		
		ement and skin integrity, check			potential to be affected by the		
	skin daily, was date	- •			same deficient practice is all		
					residents have the potential to	he	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/26/2023 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A current contracture of the right hand care plan, affected by this deficient practice. initiated 5/25/23, indicated an intervention for A housewide audit by the Director right palm guard to protect skin integrity, dated of Nursing has been completed on 5/25/23. all resident ADL care plans. All ADL care plans have been Resident 23's clinical record lacked refusals to reviewed and updated to include wear the right padded palm guard. but not limited to mobility. 3.) The measures that have been On 6/22/23 at 9:14 A.M., CNA (certified nurse put into place to ensure that the aide) 5 was observed to provide a partial bed bath deficient practice does not recur is for Resident 23. Resident 23 was not observed to that a mandatory in-service has be wearing any type of appliance on the right been conducted by the Director of hand. When completed, CNA 5 left the room Nursing for all members of the without mentioning the adaptive device to interdisciplinary team on the Resident 23. At that time, CNA 5 indicated facility's policy related to the Resident 23 refused to wear the adaptive device development and implementation for her right hand, but staff should ask the of a comprehensive care plan and resident about wearing it. CNA 5 re-entered the following physician orders. The room, located the padded palm guard on the floor in-service focused on ensuring under Resident 23's bedside table, picked it up, each resident's care plan and and placed it on the bedside table. CNA 5 did not physician orders addresses the offer to place the guard on Resident 23's right resident's need for palm protectors hand. and is kept current based on the needs and abilities of each On 6/22/23 at 11:20 A.M., CNA 5 indicated resident. Resident 23 usually did not wear the right padded 3.) The measures that have been palm guard, but every once in a while would. She put into place to ensure that the indicated any resident refusals should have been deficient practice does not recur is reported to the nurse, but were not documented. that a mandatory in-service has been conducted by the Director of 2. On 6/19/23 at 10:45 A.M., Resident 62 was Nursing for all members of the observed lying in bed. The bed was not in the interdisciplinary team on the lowest position, and no fall mat was observed on facility's policy related to the the right side of the bed (the side closest to the development and implementation door). of a comprehensive care plan. The in-service focused on ensuring On 6/20/23 at 9:00 A.M., Resident 62 was each resident's ADL care plan observed lying in bed. The bed was in the lowest addresses the resident's needs position, but no fall mat was observed on the right and abilities as well as mobility side of the bed. and is kept current based on the

07/20/2022

	T OF HEALTH AND HU OR MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES NOF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	A. Bl	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observed lying in la lowest position, and the right side of the On 6/24/23 at 9:20 observed lying in laposition with the has observed on the On 6/20/23 at 1:26 record was review were not limited to admission MDS A indicated a moderal Resident 62 requires staff with bed most two staff with transection to the control of t	o A.M., Resident 62 was bed. The bed was in the lowest head of the bed flat. No fall mat the right side of the bed. o P.M., Resident 62's clinical ed. Diagnosis included, but to, depression. The most recent essessment, dated 5/17/23, atte cognitive impairment. ed limited assistance of two bility, extensive assistance of sfers and toileting, and was of one staff with bathing. orders included, but were not elevated due to shortness of flat, dated 5/15/23. falls care plan, initiated 5/13/23, and limited to, the following			needs and abilities of each resident. 4.) The corrective action take monitor to ensure the deficien practice will not recur is that a Quality Assurance tool has be developed and implemented the monitors the accuracy and completeness of the resident's care plans and physician order for palm protectors. The tool of monitor 6 random current residents to ensure that each the resident's current palm protector needs have an appropriate plan of care and physician order in place. This will be completed by the Direct of Nursing/Designee weekly for four weeks, then monthly for the months and then quarterly for three quarters. The outcome 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 take monitor to ensure the deficient	t een hat s ers will of tool ctor or hree of	

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5/25/23

fall mats to both left and right side of bed, dated

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

of the bed was supposed to be up or down.

the lowest position, but was unaware if the head

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practice will not recur is that a

completeness of the resident's

ADL care plans. The tool will

residents to ensure that each of

the resident's current ADL and

mobility needs have an appropriate

monitors the accuracy and

monitor 6 random current

Quality Assurance tool has been developed and implemented that

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

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		A. BUILDING B. WING	00	COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		2819	T ADDRESS, CITY, STATE, ZIP COD NORTH ST JOSEPH AVE ISVILLE, IN 47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE
	(DON) indicated the following orders or	A.M., the Director of Nursing ere was no official policy on care plans, but it was expected physician orders and care plan		plan of care in place. This to be completed by the Directo Nursing/Designee weekly fo weeks, then monthly for thre months and then quarterly for three quarters. The outcom 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 warrante	r of r four ee or e of he
F 0657 SS=E Bldg. 00	§483.21(b)(2) A comust be- (i) Developed with of the comprehens (ii) Prepared by an includes but is not (A) The attending (B) A registered not the resident. (C) A nurse aide with resident. (D) A member of fostaff. (E) To the extent participation of the representative(s). included in a residing participation of the representative is don't for the development of the representative is don't for the repre	and Revision rehensive Care Plans comprehensive care plan in 7 days after completion sive assessment. In interdisciplinary team, that limited to physician. urse with responsibility for with responsibility for the			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155348	B. W	ING		06/26	/2023
				CTREET	ADDRESS CITY STATE ZIR SOD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
	WOADE OFNIED				ORTH ST JOSEPH AVE		
PARKVIE	EW CARE CENTER			EVANS	SVILLE, IN 47720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(iii)Reviewed and	revised by the					
	interdisciplinary te	am after each assessment,					
		comprehensive and					
	quarterly review a						
			F 0	657	F - 657		07/20/2023
	Based on observation	on, interview, and record			1.) The corrective action takes	n for	
	review, the facility	failed to ensure care plan			those residents found to have		
	-	ompleted and care plans			been affected by the deficient		
		esidents reviewed for			practice is the interdisciplinary		
	Accidents, 1 of 2 re	sidents reviewed for Care			team reviewed and updated		
	Planning, 1 of 2 res	idents reviewed for Dental, and			Resident 34's oxygen care pla	ans,	
	1 of 2 residents reviewed for Respiratory Care.				Resident 51's fall care plans a	and	
	(Resident 1, Resident 22, Resident 34, Resident 51,				Resident 62's dental care plar		
	and Resident 62)				Resident 22 is no longer in the		
	,				facility.		
	Findings include:				1.) The corrective action take	n for	
					those residents found to have		
	1. On 6/20/23 at 9:2	22 A.M., Resident 34 was			been affected by the deficient		
		L (liters) oxygen with			practice is Resident 1 had a		
	humidification via r	nasal cannula. The date on the			planned care plan conference		
	tubing was 6/12 and	d the date on the			which was held and documen		
	humidification bottl	le was 6/19.			in the resident record.		
					2.) The corrective action take	n for	
	On 6/20/23 at 2:20	P.M., Resident 34's clinical			the other residents that have t		
	record was reviewe	d. Resident 34 was admitted on			potential to be affected by the		
	4/4/23. Diagnoses in	ncluded, but were not limited			same deficient practice is all		
	to, chronic obstruct	ive pulmonary disease, morbid			residents have the potential to	be	
		heart failure, and dependence			affected by this deficient pract		
		ygen. The most recent			A housewide audit has been		
	admission MDS (M	linimum Data Set) assessment,			conducted of current in house		
	dated 5/2/23, indica	ted Resident 34 was			resident's care plans by the		
	cognitively intact as	nd was on oxygen.			interdisciplinary team. All care	е	
					plans of current in house resid		
	Current physician o	rders lacked an order for			have been reviewed and upda		
	oxygen.				2.) The corrective action take		
					the other residents that have t		
	A current care plan,	, revised 5/22/23, indicated that			potential to be affected by the		
	Resident 34 had ast	hma and uses a bipap while			same deficient practice is all		
	sleeping. The care p	olan lacked oxygen settings.			residents have the potential to	be	
					affected by this deficient pract		
1	1		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/26/2023 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE **EVANSVILLE, IN 47720** PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an interview with RN 9 on 06/22/23 at 10:28 A housewide audit has been A.M., she indicated she was unable to find an conducted by the Social Services order for oxygen. She further indicated that Director of resident's records for without an order Resident 34's oxygen use could documented care conference for not be appropriately assessed. current quarter. All current residents have had a care On 6/26/23 at 10:15 A.M., a current Oxygen conference documented in the Administration policy, revised 10/7/22, was resident record for the current provided and indicated "Oxygen will be quarter. administered in accordance with physician 3.) The measures that have been orders". put into place to ensure that the deficient practice does not recur is 2. On 6/22/23 at 8:14 A.M., Resident 22's clinical a mandatory in-service has been record was reviewed. Resident 22 was admitted on provided by the Director of Nursing 3/14/23. Diagnoses included, but were not limited for the interdisciplinary team on to, mild dementia without behavioral disturbance, their responsibility for reviewing osteoarthritis, presence of right artificial hip joint, and revising as necessary of care and history of falling. The most recent quarterly plans for each resident in MDS (Minimum Data Set) Assessment, dated accordance with facility policy. 3/3/23, indicated Resident 22 had moderate The interdisciplinary team was cognitive impairment, needed extensive assistance educated on their responsibility to of 1 staff for transfers, needed extensive ensure that each resident's care assistance of 2 or more staff for toileting, and had plan is reviewed and revised as fallen once since the previous assessment. necessary at least quarterly, with any significant change in condition A progress note dated 2/4/2023 indicated or upon the resident and/or their Resident 22 sustained an unwitnessed fall without representative's request. injury. The clinical record lacked an IDT 3.) The measures that have been (Interdisciplinary Discipline Team) note and put into place to ensure that the appropriate intervention associated with this fall. deficient practice does not recur is the Social Service Director was A progress note dated 2/26/23 indicated Resident educated by the Executive 22 sustained an unwitnessed fall without injury. Director on their responsibility to The clinical record lacked an IDT note and document a summary of the care appropriate intervention associated with this fall. plan conference in the resident's clinical record at least quarterly. A current care plan, revised 4/28/23, indicated the 4.) The corrective action taken to resident was at risk for falls. The care plan lacked monitor to ensure the deficient revisions between 1/13/23 and 4/17/23. practice will not recur is that a

Quality Assurance tool has been

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/26/2023 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE **EVANSVILLE, IN 47720** PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3. On 6/22/23 at 12:39 P.M., Resident 51's clinical developed and implemented to record was reviewed. Resident 51 was admitted on monitor current resident's care 10/27/22. Diagnoses included, but were not limited plans are being reviewed and to, Alzheimer's Disease, bilateral hearing loss, and revised as necessary at least generalized muscle weakness. The most recent every quarter by the quarterly MDS assessment, dated 5/6/23, interdisciplinary team. The tool indicated Resident 51 had severe cognitive will monitor 6 random current impairment, needed extensive assistance of 2 or residents to ensure that each of more staff for transfers, needed extensive the resident's current ADL and assistance of 2 or more staff for toileting, and had mobility needs have an appropriate fallen 2 or more times since the previous plan of care in place. This tool will assessment. be completed by the Director of Nursing/Designee weekly for four A progress note dated 1/24/23 indicated Resident weeks, then monthly for three 51 sustained an unwitnessed fall without injury. months, then quarterly for three The clinical record lacked an IDT note and guarters. The outcome of this tool appropriate intervention associated with this fall. will be reviewed at the facility's Quality Assurance meetings to A progress note dated 2/27/23 indicated Resident determine if any additional action 51 sustained an unwitnessed fall without injury. is warranted. The clinical record lacked an IDT note and 4.) The corrective action taken to appropriate intervention associated with this fall. monitor to ensure the deficient practice will not recur is a A A current care plan, initiated 10/28/22, indicated Quality Assurance tool was the resident was at risk for falls. The care plan developed and implemented to lacked revisions between 1/6/23 and 3/28/23. monitor current resident's records to ensure each resident's care During an interview on 06/26/23 at 08:38 A.M., the conference is being documented DON indicated that she expected the care plan to in the resident record. This tool be updated with an intervention after a fall. She will monitor 6 random resident's further indicated that it had been difficult for IDT records by the Social Service to meet due to staffing changes. Director weekly for four weeks, then monthly for three months, 4. On 6/19/23 at 10:20 A.M., Resident 1 indicated a then quarterly for three quarters. care plan conference had not been completed in The outcome of this tool will be "a long time". reviewed at the facility's Quality Assurance meetings to determine On 6/20/23 at 1:44 P.M., Resident 1's clinical if any additional action is record was reviewed. Diagnosis included, but warranted.

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were not limited to, anxiety, depression, bipolar

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
155348			B. W	ING		06/26/	2023
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER				2819 NO	DDRESS, CITY, STATE, ZIP COD ORTH ST JOSEPH AVE VILLE, IN 47720		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		T.C.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
		otic disorder. The most recent					
		nimum data set) Assessment,					
	dated 5/12/23, indic	cated no cognitive impairment.					
	A progress note do	ted 7/22/22, indicated the IDT					
		feam) reviewed resident's plan					
		of attorney declined an					
	invitation to the car	_					
		lacked documentation that a					
	since 7/22/22.	e had been scheduled or held					
	Since //22/22.						
	On 6/22/23 at 10:56 A.M., the Director of Nursing						
	(DON) indicated ca	re plan conferences should be					
	held with the reside						
		terly or with a significant					
	-	he indicated a formal care plan					
		been done for Resident 1					
		met with with her frequently, e family to invite. She					
		eam would do a care plan					
	review weekly, but	_					
	I -	n actual care plan conference					
	in the chart.	•					
	5 0 6/10/20 10	46 4 36 P 21 2 22					
		:46 A.M., Resident 62 was					
	with no teeth.	ed. Resident 62 was observed					
	with no teem.						
	On 6/21/23 at 9:22	A.M., Resident 62 was					
		ed. At that time, she was					
	observed with no teeth and indicated she was						
		atural teeth and did not wear					
	dentures.						
	On 6/20/23 at 1.26	P.M., Resident 62's clinical					
		d. Diagnosis included, but					
		depression. The most recent					
		iinimum data set) Assessment,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COME	E SURVEY PLETED 6/2023	
	PROVIDER OR SUPPLIEF		2819 1	ADDRESS, CITY, STATE, ZIP CONORTH ST JOSEPH AVE SVILLE, IN 47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	impairment. The M	rated a moderate cognitive IDS did not indicate any dental atulous" (no teeth) was not				
		urrent diet order for a regular altered texture, with nectar 5/12/23.				
	The clinical record being edentulous.	lacked a care plan related to				
	nothing checked for	ment, dated 5/20/23, had dentition or chewing abilities eeth, dentures, or missing				
	indicated a resident care plan related to indicated if there w edentulous resident	A.M., the MDS Coordinator with no teeth should have a their dental status. He as no care plan for an , he could open up initial care IDS and go in and modify				
	Care Plans and Con was provided and in plan must berevis	A.M., a current Comprehensive ferences policy, dated 1/26/23, adicated "the resident's care ed based on changing goals, adds of the resident and in interventions".				
	3.1-35(d)(2)(B)					
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service	ed for Dependent Residents esident who is unable to of daily living receives the es to maintain good g, and personal and oral				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155348	B. WING 06/26/2023			2023	
I				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH ST JOSEPH AVE		
PARKVIE	W CARE CENTER	2			SVILLE, IN 47720		
	 I				T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	hygiene;	on interview and record			 F 677		07/20/2022
		on, interview, and record	F 06	5//	F – 677	•	07/20/2023
		failed to ensure services were			1.) The corrective action taker		
		in personal hygiene for 2 of 3			those residents found to have		
		for activities of daily living.			been affected by the deficient		
	_	s were not provided showers			practice is Resident 1's bathin	-	
		ording to preference.			preferences were reviewed wi		
	(Resident 1, Reside	ent 62)			resident and updated in care p	olan	
	F: 1: 1 1				and Resident 62's bathing		
	Findings include:				preferences were reviewed wi		
	1 0 (/10/22 / 10	10 A M D 11 (11 11 (1			resident and updated in care p		
		:18 A.M., Resident 1 indicated			2.) The corrective action taker		
	_	tting washed because the staff			the other residents that have t	he	
		odate her preference for having			potential to be affected by the		
		he indicated she had requested		same deficient practice is all			
		hair in bed with the water	residents have the potential to be				
		can, and was told that could		affected by this deficient practi			
		rash can would be too heavy		A housewide audit was conducted		cted	
		and empty. She indicated she			of current in house resident's		
		bathed twice a week, and was			shower schedule and complet		
	not getting them the	at often.			Updated shower sheets requir		
		5.4.5.4.4.4.4			resident's signature if resident		
		P.M., Resident 1's clinical			refuses shower on scheduled		
		d. Diagnosis included, but			day. Activities to now complet		
		anxiety, depression, bipolar			bathing preference sheet upor		
		otic disorder. The most recent			admission, MDS to update car		
		nimum data set) Assessment,			plans accordingly and DNS to		
	· ·	cated no cognitive impairment.			update shower schedules.		
	_	extensive assistance of one			3.) The measures that have b		
		lity, and was totally dependent			put into place to ensure that th		
	of one staff with ba	thing.			deficient practice does not rec		
					a mandatory in-service has be		
		l record indicated the following			conducted for all nursing staff	-	
		were given from 5/22/23			the Assistant Director of Nursi	-	
	through 6/20/23:	11 .13			on the facility's policies related		
	Thursday 6/8/23 (b				bathing. The nursing staff was	S	
	Monday 6/12/23(be				educated on updated shower		
		ning were documented during			sheets requiring any resident	who	
	that time period				refuses showers to sign. The		
					Activity Director was educated	l by	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348	STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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) NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 (X5) PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG 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	AND PLAN OF CORRECTION			ľ í	A. BUILDING <u>00</u>		` '	
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 not washed) Monday 6/12/23 (bed bath, hair washed) STREET ADDRESS, CITY, STATE, ZIP COD 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 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				B. W	ING			
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(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 6/12/23 (bed bath, hair washed) Monday 6/12/23 (bed bath, hair washed) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE 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	ם א פוצי /יור	IN CADE CENTER						
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 6/12/23 (bed bath, hair washed) Monday 6/12/23 (bed bath, hair washed) TAG 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	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
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 6/12/23 (bed bath, hair washed) provided, with the following for Resident 1 from 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	TAG				TAG	DEFICIENCY)		DATE
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 6/12/23 (bed bath, hair washed) Monday 6/12/23 (bed bath, hair washed) 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						_		
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 6/12/23 (bed bath, hair washed) Monday 6/12/23 (bed bath, hair washed) resident's within 72 hours. 4.) The corrective action taken to monitor to ensure the deficient practice will not recur is a Quality		•	2				nce	
washing hair) Monday 5/29/23 (bed bath, hair not washed) Monday 6/12/23 (bed bath, hair washed) Monday 6/12/23 (bed bath, hair washed) 4.) The corrective action taken to monitor to ensure the deficient practice will not recur is a Quality		•				form on all newly admitted		
Monday 5/29/23 (bed bath, hair not washed) Monday 6/12/23 (bed bath, hair washed) monitor to ensure the deficient practice will not recur is a Quality		· ·	ed bath, nothing marked for					
Monday 6/12/23 (bed bath, hair washed) practice will not recur is a Quality						4.) The corrective action take	en to	
		•						
		•	· · · · · · · · · · · · · · · · · · ·			I	ality	
Monday 6/19/23 (shower, hair washed) Assurance tool has been		Monday 6/19/23 (s.	hower, hair washed)					
developed and implemented to							to	
On 6/21/23 at 1:00 P.M., the Director of Nursing ensure that each resident is								
(DON) indicated Resident 1 had requested her hair receiving baths according to their		, ,	•					
to be washed into a trash can, and staff could not preferences. The tool will monitor						1 · ·		
		accommodate that because the trash can got too					•	
heavy. She indicated Resident 1 would not use completed and documented. The		-						
the blow up headrest for washing her hair. tool will also monitor to ensure		the blow up headre	st for washing her hair.					
new residents are submitting their						_	their	
On 6/21/23 at 10:55 A.M., CNA 7 indicated all bathing preferences upon								
showers were documented into the resident's admission. This tool will be								
electronic record, and a shower sheet filled out completed by the Director of						· · · · · · · · · · · · · · · · · · ·		
that was signed by a nurse and placed at the Nursing and/or their designee			-			_	;	
nurse's station. At that time, a weekly shower weekly for four weeks, then						_		
schedule was reviewed at the nurses station that monthly for three months and then						· · · · · · · · · · · · · · · · · · ·		
indicated Resident 1's shower days were Monday quarterly for three quarters. The			I's shower days were Monday			1 -	The	
and Thursday. outcome of this tool will be		and Thursday.						
reviewed at the facility's Quality		0 (100/100) 1 1 1 1	0.436 (374 ();7			_	-	
On 6/22/23 at 11:20 A.M., CNA (certified nurse Assurance meetings to determine			The state of the s				mine	
aide) 5 indicated Resident 1 usually requested a if any additional action is		· · · · · · · · · · · · · · · · · · ·						
bed bath (about 90% of the time), and did like her warranted.		·				warranted.		
hair washed. She indicated Resident 1 did not			ndicated Resident 1 did not					
refuse bathing.		refuse bathing.						
2. On 6/10/22 at 10:46 A.M. Pasidant 62 was		2 On 6/10/22 -4 10	0.46 A.M. Dagidant (2					
		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.		greasy and not brushed.						
On 6/21/23 at 9:22 A.M., Resident 62 was		On 6/21/23 at 0.22	A.M. Recident 62 was					
observed lying in bed with greasy hair.								
observed typing in oed with greasy han.		ooserved lying in b	cu willi greasy naif.					
On 6/20/23 at 1:26 P.M., Resident 62's clinical		On 6/20/23 at 1.26	P.M. Resident 62's clinical					
record was reviewed. Diagnosis included, but								

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155348	B. WI	NG		06/26	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	2			ORTH ST JOSEPH AVE			
	EW CARE CENTER				VILLE, IN 47720			
I AININIE	TO CALL OLIVIER	<u> </u>		LVANO	VILLE, IIV 7/120			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		depression. The most recent						
		sessment, dated 5/17/23,						
		te cognitive impairment.						
	_	d extensive assistance of two						
		and toileting, and was totally						
	-	aff with bathing. The						
	assessed.	of the MDS was not						
	assessed.						1	
	Resident 60's alinia	al record lacked a care plan						
		es for bathing or refusals.						
	related to preference	co for banning of foliabals.					1	
	Progress notes inclu	aded, but were not limited to,						
	the following:	, 580						
	_	Resident's urine from 6/15/23						
		I (urinary tract infection)						
	_	used confusion, taking pants						
		he floor urinating for the past						
	two days							
							1	
	Resident 62's clinic	al record indicated the						
	following showers/	bed baths were given from						
	5/22/23 through 6/2	20/23:						
	Friday 6/2/23 (bed	bath)						
	Monday 6/5/23 (ref	used one time)					1	
	Tuesday 6/6/23 (ref	fused one time)						
	Friday 6/9/23 (bed	bath)					1	
	Tuesday 6/20/23 (b	ed bath)						
		P.M., shower sheets were					1	
	_	following for Resident 62 from					1	
	5/22/23 through 6/2						1	
	_ ·	bed bath, hair washed in beauty						
	salon)							
		hecked between shower and					1	
	bed bath, no other i	· ·						
		necked between shower and						
	bed bath, hair not w							
		necked between shower and						
	bed bath, no other information)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
155348			B. WING		06/26/2023
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	
PARKVIF	EW CARE CENTER			NORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID	 -	STATEMENT OF DEFICIENCIE	ID	,	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
		tated had shower already and			
	wasn't taking anoth	er)			
		necked between shower and			
	bed bath, no other is				
		hecked between shower and			
	bed bath, no other is	nformation)			
	On 6/21/23 at 10:55	5 A.M., a weekly shower			
		wed at the nurses station that			
		62's shower days were			
	Wednesday and Sat	urday.			
	On 6/22/23 at 10:16 A.M., Resident 62's daughter indicated Resident 62 had always preferred				
		ing admitted to the facility on			
	5/12/23. She indica	ated Resident 62 loved to have			
	her hair washed, and	d had recently paid to have her			
	hair done, but was t	unsure if it had been done yet			
	or not.				
	On 6/22/23 at 11:55	5 A.M., a Resident Preference			
		, dated 5/12/23, was provided			
	1	with "daughter in person".			
	The form indicated	Resident 62 preferred bed			
	baths. The form wa	as not signed by Resident 62's			
	daughter.				
	On 6/22/23 at 11:20	A.M., CNA 5 indicated			
		ed showers, and had never			
		her. She indicated she would			
		at type of bathing she wanted,			
		e, she would tell her a shower.			
	She indicated Resid	lent 62 was excited to get into			
	the shower and will	allow staff to wash her hair.			
		a resident were to refuse			
		hould notify the nurse, and			
		esident three times total and			
	document all refusa	ls on the shower sheets.			
	On 6/21/23 at 2:32	P.M., facility grievances were			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155348		, ,	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/26/	ETED	
	PROVIDER OR SUPPLIER			2819 NO	DDRESS, CITY, STATE, ZIP COD DRTH ST JOSEPH AVE VILLE, IN 47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR reviewed with the for 2/2/23 "States that a	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION bllowing related to showers: ide told her there was no hot		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	asked for shower ne scheduled for that d						
	get a shower for tre- gotten any showers	asked therapist if she could atment. Pt stated she has not since she has arrived. Pt sing staff to put her on the					
	_	ning of not getting showers. ets showers when given by					
	2/27/23 "Resident had her hair washed	very upset because she hasn't in over a week"					
	showers. Patient stabin and soap and the the staff. Patient so about to call her PC	mplaining of not getting ated she asked for water in a cought it was asking a lot of upset she stated she was A (power of attorney) to come ent states she only gets by"					
	Daily Living policy and indicated "The assistance as needed daily living (ADLs) carry out activities	P.M., a current Activities of , revised 8/22/22, was provided resident will receive d to complete activities of A resident who is unable to of daily living receives the o maintain good nutrition, onal oral hygiene"					
	3.1-38(a)(3)						
F 0732 SS=C	483.35(g)(1)-(4) Posted Nurse Sta	ffing Information					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00 COMPLE			ETED	
		155348	B. WING 06/26/2023			2023	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			ORTH ST JOSEPH AVE		
	W CARE CENTER						
PARKVIE	W CARE CENTER			EVANS	VILLE, IN 47720		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	_	DATE
Bldg. 00	§483.35(g) Nurse	Staffing Information.					
	§483.35(g)(1) Data	a requirements. The facility					
	must post the follo	wing information on a daily					
	basis:						
	(i) Facility name.						
	(ii) The current dat	te.					
	(iii) The total numb	per and the actual hours					
	worked by the follo	owing categories of					
	licensed and unlic	ensed nursing staff directly					
	responsible for res	sident care per shift:					
	(A) Registered nui	rses.					
	(B) Licensed pract	tical nurses or licensed					
	vocational nurses	(as defined under State					
	law).						
	(C) Certified nurse	e aides.					
	(iv) Resident cens	us.					
		ting requirements.					
	• •	st post the nurse staffing					
		paragraph (g)(1) of this					
	•	basis at the beginning of					
	each shift.						
	(ii) Data must be p						
	(A) Clear and read						
	` '	place readily accessible to					
	residents and visit	ors.					
	2422 274 1/21 7						
		olic access to posted nurse					
	-	facility must, upon oral or					
	•	ake nurse staffing data					
	•	ıblic for review at a cost not					
	to exceed the com	imunity standard.					
	0400 05(-)(4) F	**************************************					
	§483.35(g)(4) Fac	•					
	•	e facility must maintain the					
	•	e staffing data for a					
		onths, or as required by					
	State law, whichever	ver is greater. on, interview, and record	EOS	722	E 722		07/20/2022
			F 07	32	F - 732	for	07/20/2023
	review, the facility	failed to ensure the daily			1.) The corrective action taken	IOF	

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07/28/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/26/2023 155348 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720 PARKVIEW CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE posted nurse staffing reflected the actual hours those residents found to have worked by staff for 3 of 6 days during the survey. been affected by the deficient practice is the Posted Nurse Findings include: Staffing sheet accurately reflects the time of each shift. No resident During an observation on 6/19/23 at 10:30 A.M., was identified as being affected in the posted daily staffing sheet included the date, this statement of deficiencies. census, RN (Registered Nurse), LPN (Licensed The form being utilized was not Practical Nurse), and CNA (Certified Nurse Aide) specific enough and was updated columns with number present and total hours during the survey process on worked for "days, evenings, and nights". The 6/26/2023 when it was brought to sheet did not indicate the time frame of the the Executive Director's attention. different shifts and lacked actual hours worked by 2.) The corrective action taken for staff. the other residents that have the potential to be affected by the On 6/21/23 at 9:20 A.M., the posted daily staffing same deficient practice is all sheet lacked actual hours worked by staff. residents have the potential to be affected by this deficient practice. On 6/24/23 at 9:18 A.M., the posted daily staffing The Executive Director sheet lacked actual hours worked by staff. implemented a new form for Posted Nurse Staffing which are On 6/26/23 at 9:00 A.M., The Director of Nursing now accurate including the actual and Administrator indicated they were unaware time of each shift worked by that the posted daily staffing sheets were required nursing staff. to have actual hours indicated on them, and that it 3.) The measures that have been was assumed visitors would know what hours put into place to ensure that the "days, evenings, and nights" were. deficient practice does not recur is a mandatory in-service has been On 6/26/23 at 9:09 A.M., a current Staffing policy, conducted by the Executive dated 7/27/22, was provided and indicated "The Director for the Director of Nursing facility must post the following information on a and scheduler on the facility's daily basis ... The total number and the actual policy related to the completion of hours worked ..." 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155348	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/26/2023
	PROVIDER OR SUPPLIE		2819 1	ADDRESS, CITY, STATE, ZIP COD NORTH ST JOSEPH AVE SVILLE, IN 47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				monitor to ensure the deficient practice will not recur is a Quarter 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 week then monthly for three months then quarterly for three quarter. The outcome of this tool will be reviewed at the facility's Qualit Assurance meetings to determ if any additional action is warranted.	allity co cks, and rs. e ty

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