PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING <u>00</u> COMPL		
		155778	B. WING		09/16/2017	
			STREE	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		E MAIN		
PARKVIE	EW HEALTHCARE			ATTICA, IN 47918		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00			E 0000	0.1.6.2047		
		or the Investigation of	F 0000	October 6, 2017		
		239907. This resulted in				
		nded Survey-Substandard				
	Quality of Care	- Immediate Jeopardy.				
	Complaint IN00	0239907 - Substantiated.				
	•	eficiencies related to the				
		cited at F223, F225, F226				
		310d dt 1 223, 1 223, 1 220		Indiana State Department of Health		
	Survey dates: S	September 13 - 16, 2017		indiana state Department of Fleatti	1	
				2 North Meridian Street		
	Facility number	: 000323		Indiananolis IN 46204		
	Provider numbe	er: 155778		Indianapolis, IN 46204		
	AIM number: 1	100288440				
	Census Bed Typ	pe:				
	SNF/NF: 41			Des Communication CO2D44		
	Total: 41			Re: Survey Event ID 692R11		
				Immediate Jeopardy (IJ)		
	Census Payor T	ype:				
	Medicare: 2					
	Medicaid: 30					
	Other: 9					
	Total: 41			Door Mathews Forters		
	10tui. 71			Dear Mathew Foster:		
	These deficienc	ies reflect State Findings		Director		
	cited in accorda	nce with 410 IAC		Lana Tarra Cara		
	16.2-3.1.			Long-Term Care		
	Quality review	completed on September				
	22, 2017.	completed on september				
	22, 2017.					
	I			l	L	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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		IDENTIFICATION NUMBER: 155778	A. BUILDING B. WING	00	COMPLETED 09/16/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W HEALTHCARE		1212 E ATTICA	MAIN A, IN 47918	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
				On September 16, 2017, a Complair (IN00239907) Survey was conducted at the above referenced facility by the Division of Long Term Care, Indiana State Department of Health to determine the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Attached you will find the completed Plan of Correction (POC) Respectfully submitted, Melinda S. Jones, HFA Administrator Parkview Healthcare	
F 0223 SS=J Bldg. 00	SECLUSION 483.12	SE/INVOLUNTARY			

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155778	B. W	NG		09/16/	2017
	PROVIDER OR SUPPLIER	2	•	1212 E	ADDRESS, CITY, STATE, ZIP CODE MAIN A, IN 47918	<u> </u>	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	DROUDENG N. AN OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	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	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	abuse, neglect, m property, and exp subpart. This incl freedom from corp involuntary seclus chemical restraint resident's sympto 483.12(a) The fact (a)(1) Not use ver physical abuse, co involuntary seclus Based on observ record review, the prevent abuse in observed to physical prevent gettin resulted in three affected 1 of 2 reabuse. (Resident The Immediate 3.09/6/17 when state Licensed Practice sitting on the lap wheelchair, in the resident from risobserved restrain which resulted in Administrator with the subsection of the su	isappropriation of resident loitation as defined in this udes but is not limited to coral punishment, sion and any physical or not required to treat the ms. illity must-bal, mental, sexual, or corporal punishment, or cion; ration, interview, and the facility failed to that a staff member was sically restrain a resident g out of a chair, which areas of bruising. This residents reviewed for t B) Jeopardy began on the facility failed to the hallway, to prevent the cing. The nurse was then the hing the resident's arms, in bruising. The sas notified of the lardy on 9/14/17 at 3:25	F 02		1. It is the intent of this facility to prevent abuse LPN #11 was terminated. Indiana Professional Licensing Board was contacted in order report LPN# 11's allegation of abuse. Resident "B" was assessed fo injuries. Resident "B"'s physician and family were notified of the incident. Police were called regarding incident and employee. Consulting company was hired September 15, 2017 to implement State and Federal regulations. Resident's weekly skin assessments were reviewed a no injuries of unknown origin were identified. 2. No other residents were identified, however, all resider had the potential to be affecte	to r d	10/16/2017
	C	25 a.m., Resident B was			All employees were in-service and given a pre- and post-test	d	
			1		I		

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STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155778 B. WING 09/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1212 E MAIN PARKVIEW HEALTHCARE ATTICA, IN 47918 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Abuse Prevention Policies and observed seated in a wheelchair across Procedures. Emphasis was made from the nurses' station. She was very on the following: quiet, was alert, but did not respond 1.escorting the person from the verbally. Her arms above the wrists were facility who has been accused of observed and noted to be bruised. abusing a resident and/or closely monitoring the accused; 2.immediately reporting all On 9/13 /17 at 10:55 a.m., Qualified allegations of abuse to the Medication Aide (QMA) #1 was Administrator; 3.thoroughly investigating all interviewed. She indicated she had come allegations of abuse. to the facility to work on 9/6/17 at 6:00 Social Services will inform residents a.m. She indicated she had gone to the in a Resident Council meeting of nurses' station to get keys for the their right to be free from abuse. medication cart and observed LPN #11 The Activity Director informs sitting on Resident B's lap and holding residents, in their monthly Resident her hands down. She had reported it to Council meeting, of their Resident Rights. the Restorative Aide #2 who had just come on duty, and asked her to walk the Social Service Person/Designee resident to get away from the situation will conduct a random audit of five and due to the resident being anxious and (5) residents weekly for four (4) consecutive weeks. These combative. The Restorative Aide took residents will be interviewed to the resident for a walk and found the ensure that any alleged violations resident had been wet through her slacks. are identified, properly investigated and reported She was toileted and changed then according to facility policy and walked to the dining room. The staff procedure. member indicated she had not known Administrator/Designee will conduct when LPN #11 had left the building, or a random audit of five (5) employee where she had gone, after she intervened weekly for four (4) consecutive with the resident. The OMA indicated the weeks. These employees will be LPN could be intimidating with staff. interviewed to verify understanding of current Abuse Policy and Procedures. Re-education will be On 9/13/17, at 1:30 p.m., Restorative provided at the time of the Aide #2 was interviewed. She indicated interview, if needed. she had seen LPN #11 sitting on the DON/Designee will examine all resident's lap and holding Resident B's residents' skin weekly for suspicious

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	IULTIPLE CO UILDING	ONSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	155778	B. W		00	09/16/	
		155776	B. 11			09/10/	2017
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW HEALTHCARE			1212 E ATTICA	MAIN A, IN 47918		
	ı	FATEMENT OF DEFICIENCIES	1	<u> </u>	,		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	arms down. She	retrieved the resident's			injury/injury of unknown origin. If		
	walker and escor	ted her to the restroom.			any resident is identified,		
		e had been wet through			Administrator/DON will implement		
		was cleaned up, placed			abuse prevention policy and		
		voided. She then was			procedure.		
	· ·	dining room before			Summary of the interviews and incidence of re-education, if		
		ovided with a banana.			required, will be discussed in		
		s calm. The Restorative			morning meeting weekly.		
		she had reported the			This Plan of Correction will be		
		iness Office Manager			monitored at the monthly Quality		
		I in the facility, between			Assurance meeting until such time		
		00 a.m. The staff			consistent substantial compliance has been met.		
		d she had not been aware					
		11 was in the facility					
		eident and did not know					
	1	building. The aide					
		N could be intimidating					
		ne was not sure if she					
	· ·	f she would hit her.					
	On 9/14/17 at 10	0:30 a.m., CNA #12 was					
	interviewed. Sh	e indicated the resident					
	becomes "fidget	y" when she needs to use					
	the restroom, has	s pain, or is hungry.					
	On 9/14/17 at 11	:00 a.m., The Business					
	Office Manager,	the Administrator, The					
	Interim Director	of Nursing, and the					
	Social Service de	esignee were interviewed					
	in a group interv	iew. Employee #4					
	indicated she had	d notified the					
l	Administrator w	hen she entered the					
	facility. The Ad	ministrator indicated it					
	was around 8:00	a.m. at which time an					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	(X2) MULTIF A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE : COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER		12	12 E N	DDRESS, CITY, STATE, ZIP CODE MAIN IN 47918		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	she had clocked a.m., after she en	begun. She indicated LPN #11 out for 7:00 tered the building. The land to clocked herself out.					
	QMA was interv She indicated she	:40 p.m., night shift iewed on the telephone. e was suprised when she ncident, but the LPN ating to staff.					
	on 9/15/17 at 12:	terviewed by telephone 45 p.m. She indicated e intimidating staff					
	member had been and was terminated of the resident after three new bruises the area that the seen restraining, documented on 9 bruise to the right to the wrist 4 certiregular boarder p.m.: left forearm wrist 7 cm with it 9/6/17 at 3:51 p.m. cm round.	e investigation, 8/17, concluded the staff in abusive to Resident B sted. The skin assessment iter the incident included in a reas on the arms in staff member had been. The measurements were 10/6/17 at 3:49 p.m. (a) A st forearm just proximal intimeters (cm) with s. (b) 9/6/17 at 3:51 in bruise just proximal to rregular boarder and (c) in.: bruise right arm 1					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER			1212 E N	DDRESS, CITY, STATE, ZIP CODE MAIN IN 47918		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	included, but wa	8 p.m. Diagnoses s not limited to, chaviors, anxiety, and					
	the resident's bristatus as 99 (resi interview). The resident's status The resident's as required extensiv mobility, transfe hygiene and toile incontinent of boresident utilized	S) dated 6/27/17, coded ef interview for mental dent unable to complete facility assessment of the was severely impaired. sessment included re assistance for bed rs, ambulation, dressing, eting, frequently owel and bladder. The a wheelchair and walker.					
	to incident, including limited to: diagnostic behavioral disturbing impaired decision impaired memore incoherent speece 6/27/17. Interves anticipate resides preferences, call smile and use geommunication, given prior to precare plan with in most recent reviews.	nt's needs and the resident by name,					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155778		00	COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER EW HEALTHCARE	1212 E	DDRESS, CITY, STATE, ZIP CODE MAIN , IN 47918		·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	impaired cognition. Interventions, dated, 6/22/17 indicated, but were not limited to ask the resident to try expressing herself with gestures, ask simple yes/no questions and give her time to answer. Most of the time she will respond "yes" first, repeat question and ask again. Another careplan with initial date of 2/8/17 and reviewed as current on 9/6/17, addressed new placement in facility may require time to adjust. Interventions included, but were not limited to, provide comfort, support and reassurance. Know that resident was a homemaker and an LPN, went to the Lutheran church, likes dogs, enjoys the outdoors, and likes country music. Make conversation with her and reminisce with her as able. The facility's policy titled "Residential Rights", no date, provided by the Administrator on 9/14/17 at 11:30 a.m., included but was not limited to: "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THIS TETHY	or conduction	155778	B. W		00	09/16/	
		100770		CTDEET A	DDDESS CITY STATE ZID CODE	00/10/	2011
NAME OF F	PROVIDER OR SUPPLIER			1212 E I	ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW HEALTHCARE				., IN 47918		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		required to treat the					
		al symptoms. When the					
		is indicated, the facility					
		st restrictive alternative					
	for the least amo						
	1	ng re-evaluation of the					
		tsThe facility must					
		lement written policies					
		hat: Prohibit and prevent					
	_	nd exploitation of					
	residents and mi	sappropriation of					
	resident property	7. Establish policies and					
	procedures to in	vestigate any such					
	allegations, and	Include training on					
	policies and prod	cedures developed. The					
	facilities must al	so provide training to					
	their staff that at	a minimum educates					
	staff on Activitie	es that constitute abuse,					
	neglect, exploita	tion, or the					
	misappropriation	n of resident property.					
	Dementia manag	gement and resident					
	abuse prevention	1"					
	The facility's po	licy titled "Abuse					
	, ,	orting, and Investigation					
		edure" provided by the					
	1 *	n 9/14/17 at 11:30 a.m.,					
		s not limited to: "Policy:					
	· ·	f Parkview Healthcare to					
		ents from abuse, neglect,					
	_	n of resident property,					
		This includes but is not					
	limited to freedo						
		oluntary selection [sic]					
	Pumamient, illv	oraniary sciential [sic]					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	î ´	JILDING	nstruction 00	(X3) DATE COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER			1212 E I	ADDRESS, CITY, STATE, ZIP CODE MAIN 1, IN 47918		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	required to treat symptoms. Resp Definitions: About of injury, unreas intimidation, or presulting physical anguish. Abuse by an individual, goods or service attain or maintain psychosocial we. The immediate jegodicies and proof prohibition, and investigation of night shift staff rowere audited for background checkground checkgr	also includes deprivation including a caretaker of a that are necessary to a physical, mental and all-being. eopardy that began on eved on 9/16/17 when the dall regular staff on the edures for abuse expanded the the allegation to include members. Employee files					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155778	A. BUILL B. WING	DING	00	COMPL 09/16/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F 0225 SS=J Bldg. 00	exploitation, misar mistreatment by a (ii) Have had a find nurse aide registry neglect, exploitation residents or misar property; or (iii) Have a disciplinagainst his or here state licensure boo of abuse, neglect, of residents or mis property. (4) Report to the Solicensing authorities actions by a court employee, which we service as a nurse (c) In response to	EPORT IDIVIDUALS Ility must- otherwise engage Ind guilty of abuse, neglect, oppopriation of property, or court of law; Iding entered into the State of concerning abuse, on, mistreatment of oppopriation of their Inary action in effect professional license by a dy as a result of a finding exploitation, mistreatment cappropriation of resident Istate nurse aide registry or es any knowledge it has of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	COMPL	
		155778	B. WIN	<u> </u>		09/16/	2017
NAME OF I	PROVIDER OR SUPPLIEF	}		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1212 E I			
PARKVI	EW HEALTHCARE			ATTICA	., IN 47918		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility must:						
	(1) Ensure that all	alleged violations					
		eglect, exploitation or					
		uding injuries of unknown					
	source and misap	propriation of resident					
		rted immediately, but not					
		after the allegation is					
		s that cause the allegation					
		esult in serious bodily than 24 hours if the events					
		egation do not involve					
		result in serious bodily					
		nistrator of the facility and					
		ncluding to the State					
		nd adult protective services					
		rovides for jurisdiction in					
	_	cilities) in accordance with					
	State law through	established procedures.					
	(2) Have evidence	e that all alleged violations					
	are thoroughly inv	_					
		-					
		r potential abuse, neglect,					
		streatment while the					
	investigation is in	progress.					
	(4) Report the res	ults of all investigations to					
		or his or her designated					
		d to other officials in					
	accordance with S	State law, including to the					
		ncy, within 5 working days					
		d if the alleged violation is					
	verified appropriation be taken.	te corrective action must					
		ention interview and	F 022	25	It is the intent of this facility to		10/16/2017
		ration, interview, and	1, 022		prevent abuse. If abuse has		10/10/201/
		ne facility failed to			occurred, it is the intent of this		
	-	that a staff member was			facility to immediately escort the		
	1	sically restrain a resident			suspected abuser from the facility		
		g out of a chair, which			and/or monitor closely the accused		
	resulted in three	areas of bruising. The			Report immediately allegation of		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPLETED
		155778	B. W	ING		09/16/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			1212 E		
PARKVIE	EW HEALTHCARE				A, IN 47918	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	staff member wa	s not escorted			abuse to the Administrator and	
	immediately from	n the facility, or closely			thoroughly investigate the allegatio	n
	monitored for a	period of time. The			of abuse.	
	incident was not	immediately reported to			1.	
		r, and had not been			LPN #11 was terminated.	
		tigated. The staff			Indiana Professional Licensing Board was contacted in order to report	u
		2015, had not had			LPN# 11's allegation of abuse.	
	·	done. This affected 1 of			Resident "B" was assessed for	
					injuries.	
		wed for abuse. (Resident			Resident "B"'s physician and family	
	B)				were notified of the incident.	
					Police were called regarding incider	nt
	The Immediate J	eopardy began on			and employee.	
	09/6/17 when sta	aff members observed			Consulting company was hired	
	LPN #11 sitting	on the lap of a resident			September 15, 2017 to implement	
	_	in the hallway, to prevent			State and Federal regulations.	
	· ·	rising. The nurse was			Resident's weekly skin assessments	
		straining the resident's			were reviewed and no injuries of	
					unknown origin were identified.	
		ilted in bruising. The			2.	
	Administrator wa				No other residents were identified,	
	immediate jeopa	rdy on 9/14/17 at 3:25			however, all residents had the potential to be affected.	
	p.m.				3.	
					All employees were in-serviced and	
	Findings include	:			given a pre- and post-test on Abuse	
					Prevention Policies and Procedures.	
	On 9/13/17, 10:2	25 a.m., Resident B was			Emphasis was made on the	
	· ·	in a wheelchair across			following:	
		station. She was very			a. escorting the person from the	
		but did not respond			facility who has been accused of	
		*			abusing a resident and/or closely	
	<u> </u>	ms above the wrists were			monitoring the accused;	
	observed and not	ted to be bruised.			b. immediately reporting all	
					allegations of abuse to the	
	On 9/13 /17 at 10	0:55 a.m., Qualified			Administrator;	
	Medication Aide	(QMA) #1 was			c. thoroughly investigating all	
	interviewed. She	e indicated she had come			allegations of abuse. Social Services will inform residents	
			•		. Juliai Jervii es Will HillOfffi (esidents	

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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	JILDING	00	COMPLE	ETED
		155778	B. W	ING		09/16/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1212 E			
PARKVIE	W HEALTHCARE				., IN 47918		
(X4) ID	CLIMMA DV C	FATEMENT OF DEFICIENCIES	1	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1110		,		1710	in a Resident Council meeting of		DITTE
		work on 9/6/17 at 6:00			their right to be free from abuse.		
	a.m. She indicated she had gone to the nurses' station to get keys for the				The Activity Director informs		
		-			residents, in their monthly Resident		
		and observed LPN #11			Council meeting, of their Resident		
	sitting on Reside	nt B's lap and holding			Rights.		
	her hands down.	She had reported it to			4.		
	the Restorative A	Aide #2 who had just			Social Service Person/Designe		
		d asked her to walk the			will conduct a random audit of		
		vay from the situation			(5) residents weekly for four (4	.)	
	_	sident being anxious and			consecutive weeks. These residents will be interviewed to	,	
		Restorative Aide took			ensure that any alleged violation	I	
		walk and found the			are identified, properly		
					investigated and reported		
		n wet through her slacks.			according to facility policy and		
		and changed then			procedure.		
	walked to the dir	ning room. The staff			Administrator/Designee will conduc		
	member indicate	d she had not known			a random audit of five (5) employee		
	when LPN #11 h	ad left the building, or			weekly for four (4) consecutive		
	where she had go	one, after she intervened			weeks. These employees will be		
		. The QMA indicated the			interviewed to verify understanding		
		timidating with staff.			of current Abuse Policy and Procedures. Re-education will be		
	Erry could be in	umidating with starr.			provided at the time of the		
	On 0/12/17 at 1	20 m m Dontomatica			interview, if needed.		
		30 p.m., Restorative			DON/Designee will examine all		
		rviewed. She indicated			residents' skin weekly for suspicious		
		N #11 sitting on the			injury/injury of unknown origin. If		
		l holding Resident B's			any resident is identified,		
	arms down. She	retrieved the resident's			Administrator/DON will implement		
	walker and escor	ted her to the restroom.			abuse prevention policy and		
	She indicated she	e had been wet through			procedure.		
	her slacks. She	was cleaned up, placed			Summary of the interviews and		
		voided. She then was			incidence of re-education, if		
	· ·	dining room before			required, will be discussed in		
		ovided with a banana.			morning meeting weekly.		
	· ·	s calm. The Restorative			This Plan of Correction will be monitored at the monthly Quality		
					Assurance meeting until such time		
	Aide, indicated s	he had reported the			Assurance meeting until such tillle		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		155778	B. W	ING		09/16/	
NAME OF A	DOLUBER OF GURNI ER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1212 E			
PARKVII	EW HEALTHCARE			ATTICA	A, IN 47918		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1.10		ee #4 when she arrived		1110	consistent substantial compliance		5.112
		etween 6:45 a.m. and			has been met.		
	1	aff member indicated					
	she had not been	aware of where LPN					
	#11 was in the fa	icility following the					
	incident and did	not know when she left					
	the building. The	e aide indicated the LPN					
		ating with staff, and she					
		ne walked her out if she					
	would hit her.						
	On 9/14/17 at 9::	55 a.m. tha					
		as interviewed. She					
		hift staff had not been					
		ng the investigation as					
		nessed the incident and					
	were leaving. Up						
		ree day shift staff had					
	been interviewed	during the investigation					
	and 15 residents	had been interviewed.					
		00 1 5 :					
		:00 a.m., the Business					
		the Administrator, The					
		of Nursing, and the esignee were interviewed					
		iew. Employee #4					
	indicated she had						
		hen she entered the					
		ministrator indicated it					
	_	a.m. at which time an					
		l begun. She indicated					
	_	LPN #11 out for 7:00					
	a.m., after she er	ntered the building. The					
	staff member had	d not clocked herself out.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	onstruction 00	(X3) DATE COMPL		
		155778	B. W	ING		09/16/	2017
NAME OF I	PROVIDER OR SUPPLIER			1212 E	ADDRESS, CITY, STATE, ZIP CODE		
PARKVII	EW HEALTHCARE				., IN 47918		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
	QMA was intervent She indicated she heard about the incould be intimided. CNA #15 was in on 9/15/17 at 12 the LPN could be members. The results of the completed on 9/3 member had been and was terminated of the resident at three new bruises the area that the seen restraining. In documented on 9/3 to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the seen restraining. It is to the wrist 4 certain the wrist 7 cm with 19/6/17 at 3:51 p. cm round. Resident B's clim on 9/14/17 at 2:3 included, but was	terviewed by telephone (45 p.m. She indicated the intimidating with staff) e investigation, (8/17, concluded the staff) on abusive to Resident B (15 ted.) The skin assessment of the incident included the dareas on the arms in staff member had been. The measurements were (9/6/17 at 3:49 p.m. (a) A (15 to rearm just proximal intimeters (cm) with (15 to b) 9/6/17 at 3:51					

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	OF CORRECTION IDENTIFICATION NUMBER: 155778	A. BUILDING B. WING	00	COMPLETED 09/16/2017				
	PROVIDER OR SUPPLIER EW HEALTHCARE	1212 E	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	A quarterly Minimum Data Set assessment (MDS) dated 6/27/17, coded the resident's brief interview for mental status as 99. The facility assessment of the resident's status was severely impaired. The resident's assessment included required extensive assistance for bed mobility, transfers, ambulation, dressing, hygiene and toileting, frequently incontinent of bowel and bladder. The resident utilized a wheelchair and walker. The facility's policy titled "Residential Rights", no date, provided by the Administrator on 9/14/17 at 11:30 a.m., included but was not limited to, "The facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Establish policies and procedures to investigate any such allegations, and Include training on policies and procedures developed. The facilities must also provide training to their staff that at a minimum educates staff on Activities that constitute abuse, neglect, exploitation, or the misappropriation of resident property. Dementia management and resident abuse prevention"							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	00	COMPL		
ANDILAN	or connection	155778	B. W.		00	09/16/	
					DDDEGG GITH GTATE ZIP GODE	03/10/	
NAME OF F	PROVIDER OR SUPPLIER			1212 E	ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW HEALTHCARE				, IN 47918		
(X4) ID		FATEMENT OF DEFICIENCIES		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 APPROPRIA DEFICIENCY)	ATE	DATE
	The facility's pol	icy titled "Abuse					
		orting, and Investigation					
	_	edure" provided by the					
	_	1 9/14/17 at 11:30 a.m.,					
		s not limited to: "Policy:					
	It is the policy of	f Parkview Healthcare to					
		ents from abuse, neglect,					
	•	of resident property,					
	* * *	This includes but is not					
	limited to freedo						
		oluntary selection [sic]					
	and any physical	or chemical restraint not					
	required to treat	the resident's medical					
	_	oonsibility: All Staff					
	Definitions: Ab	use - the willful infliction					
	of injury, unreas	onable confinement,					
	intimidation, or j	ounishment with					
	resulting physica	ll harm, pain or mental					
	anguish. Abuse	also includes deprivation					
	by an individual,	including a caretaker of					
	goods or service	s that are necessary to					
	attain or maintai	n physical, mental and					
	psychosocial we	ll-being8. All abuse					
	allegations must	be reported to the					
	Administrator in	nmediately and to the					
	resident's represe	entative (sponsor,					
	responsible party	y) within 24 hours of the					
	report. Failure to	o report will result in					
	disciplinary action	on; up to and including					
	immediate termi	nation. 9. The					
	Administrator is	the designated					
	individual respon	nsible for coordinating					
	all efforts in the	investigation of abuse					
	allegations and f	or assuring that all					
	I						l .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155778		l í	JILDING	NSTRUCTION 00	(X3) DATE COMPI 09/16	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 0226	The immediate jo 9/6/17 was remo facility inservice policies and proop prohibition policies investigation of the night shift staff resulting were audited for background checkground check	ies, and expanded the the allegation to include members. Employee files current license, eks, and completed moncompliance remained to and severity level of with the potential formal harm that is not redy because of the continued monitoring.							
SS=J Bldg. 00	DEVELOP/IMPLM ETC POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and prexploitation of resimisappropriation of	st develop and implement d procedures that:							
		ch allegations, and							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155778	B. W	ING		09/16/	2017
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOIT EIEF			1212 E			
PARKVI	EW HEALTHCARE			ATTICA	A, IN 47918		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(3) Include training §483.95,	g as required at paragraph					
	addition to the free and exploitation refacilities must also staff that at a mini (c)(1) Activities the neglect, exploitation of resident proper (c)(2) Procedures abuse, neglect, exploitation of the staff that at a mini (c)(1) Activities the neglect, exploitation of the staff that at a mini (c)(1) Activities the neglect, exploitation of the staff that at a mini (c)(1) Activities that at a mini (c)(1) Activities the neglect, exploitation of the staff that at a mini (c)(1) Activities that at	t, and exploitation. In edom from abuse, neglect, equirements in § 483.12, o provide training to their mum educates staff on- at constitute abuse, on, and misappropriation ty as set forth at § 483.12. for reporting incidents of exploitation, or the of resident property					
	abuse prevention.						
		ration, interview, and	F 02	226	1.		10/16/2017
	-	ne facility failed to			It is the intent of this facility to implement written policies and		
	implement writte	*			procedures that prohibit and		
		prohibit and prevent			prevent abuse.		
		itnessed physical staff to			LPN #11 was terminated.		
		policies to protect, report,			Indiana Professional Licensing Board	t l	
	_	were not implemented for			was contacted in order to report		
		estigations reviewed.			LPN# 11's allegation of abuse. Resident "B" was assessed for		
	(Resident B)				Resident "B" was assessed for injuries.		
					Resident "B"'s physician and family		
	The Immediate J	Jeopardy began on			were notified of the incident.		
	09/6/17 when sta	aff members observed			Police were called regarding inciden	it	
	LPN #11 sitting	on the lap of a resident			and employee.		
	in a wheelchair,	in the hallway, to prevent			Consulting company was hired		
	the resident from rising. The nurse was				September 15, 2017 to implement		
	then observed re	straining the resident's			State and Federal regulations. Resident's weekly skin assessments		
	arms, which resu	alted in bruising. The			were reviewed and no injuries of		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	ETED
		155778	B. WING	3		09/16/2	2017
			- 	STREET A	ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIEF	₹		1212 E			
PARKVIE	EW HEALTHCARE				a, IN 47918		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Administrator w	as notified of the			unknown origin were identified.		
	immediate jeopa	ordy on 9/14/17 at 3:25			2.		
	p.m.				No other residents were identified,		
					however, all residents had the		
	Findings include:				potential to be affected. 3.		
					All employees were in-serviced and		
	On 0/12/17 10:	25 a.m., Resident B was			given a pre- and post-test on Abuse		
					Prevention Policies and Procedures.		
		in a wheelchair across			Emphasis was made on the		
		station. She was very			following:		
	_	but did not respond			1.escorting the person from the		
	verbally. Her ar	rms above the wrists were			facility who has been accused of		
	observed and no	ted to be bruised.			abusing a resident and/or closely		
					monitoring the accused;		
	On 9/13 /17 at 1	0:55 a.m., Qualified			2.immediately reporting all		
	Medication Aide				allegations of abuse to the		
		e indicated she had come			Administrator;		
		work on 9/6/17 at 6:00			3.thoroughly investigating all		
	_				allegations of abuse.		
		ted she had gone to the			Social Services will inform residents		
		get keys for the			in a Resident Council meeting of their right to be free from abuse.		
		and observed LPN #11			The Activity Director informs		
	sitting on Reside	ent B's lap and holding			residents, in their monthly Resident		
	her hands down.	She had reported it to			Council meeting, of their Resident		
	the Restorative A	Aide #2 who had just			Rights.		
	come on duty,an	nd asked her to walk the			4.		
	resident to get a	way from the situation			Social Service Person/Designe		
	_	esident being anxious and			will conduct a random audit of		
		Restorative Aide took			(5)residents weekly for four (4))	
		a walk and found the			consecutive weeks. These residents will be interviewed to	,	
		n wet through her slacks.			ensure that any alleged violation		
		•			are identified, properly	-	
	She was toileted and changed then walked to the dining room. The staff member indicated she had not known				investigated and reported		
					according to facility policy and		
					procedure.		
		had left the building, or			Administrator/Designee will conduc		
	where she had g	one, after she intervened			a random audit of five (5) employee		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	ONSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155778	B. W		00	09/16/	
		155776	Б. 11	-		09/10/	2017
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	W HEALTHCARE			1212 E	MAIN 1, IN 47918		
	-				A, III 47 9 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		. The QMA indicated the		IAG	weekly for four (4) consecutive		DATE
		•			weeks. These employees will be		
	LFN could be iii	timidating with staff.			interviewed to verify understanding	3	
	0.0/10/17 1.00				of current Abuse Policy and		
		30 p.m., Restorative			Procedures. Re-education will be		
		erviewed. She indicated			provided at the time of the		
		N #11 sitting on the			interview, if needed.		
		I holding Resident B's			DON/Designee will examine all residents' skin weekly for suspiciou	ς.	
		retrieved the resident's			injury/injury of unknown origin. If	•	
		ted her to the restroom.			any resident is identified,		
		e had been wet through			Administrator/DON will implement		
	her slacks. She was cleaned up, placed				abuse prevention policy and		
	· ·	voided. She then was			procedure.		
		dining room before			Summary of the interviews and		
		ovided with a banana.			incidence of re-education, if required, will be discussed in		
		calm. The Restorative			morning meeting weekly.		
	•	he had reported the			This Plan of Correction will be		
	event to the Busi				monitored at the monthly Quality		
	_	ne arrived in the facility,			Assurance meeting until such time		
		n. and 7:00 a.m. The			consistent substantial compliance		
		licated she had not been			has been met.		
		LPN #11 was in the					
		g the incident and did not					
		eft the building. The					
	aide indicated th						
	_	n staff, and she was not					
	sure if she walke	d her out if she would					
	hit her.						
l							
	On 9/14/17 at 9::						
		as interviewed. She					
	_	hift staff had not been					
İ		ng the investigation as					
İ		nessed the incident and					
	were leaving. Sl	ne indicated three day					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILD		A. BUILDING B. WING	OING 00 COMPLETE CONSTRUCTION (A3) DATE SOFT (DING 00) COMPLETE (DING 09/16/20)		
	PROVIDER OR SUPPLIER		1212 E	ADDRESS, CITY, STATE, ZIP CODE MAIN A, IN 47918	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	shift staff members and 15 residents	ers had been interviewed, interviewed.			
	Office Manager, Interim Director Social Service de in a group intervimanager indicate Administrator will facility. The Administrator will facility will facility. The Administrator will facility will	ed she had notified the nen she entered the ministrator indicated it a.m. at which time an begun. She indicated LPN #11 out for 7:00 tered the building. The d not clocked herself out. :40 p.m., night shift iewed on the telephone. It was suprised when she incident, but the LPN			
	member had been and was terminat of the resident af	e investigation, 8/17, concluded the staff in abusive to Resident B sed. The skin assessment ter the incident included d areas on the arms in			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155778		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/16/	ETED	
	PROVIDER OR SUPPLIER			1212 E	ADDRESS, CITY, STATE, ZIP CODE MAIN A, IN 47918	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	seen restraining. documented on 9 bruise to the right to the wrist 4 cer irregular boarder p.m.: left forear wrist 7 cm with 9/6/17 at 3:51 p.cm round. The facility's pol Rights", no date, Administrator or included but was resident has the rabuse, neglect, no resident property includes but is not from corporal purseclusion and an restraint not requiresident's symptomensure that the rephysical or chemfor purposes of conductive and that are not resident's medical use of restraints must use the least for the least amondocument ongoin need for restraint.	a 9/14/17 at 11:30 a.m., a not limited to, "The right to be free from hisappropriation of a, and exploitation. This ot limited to freedom hishment, involuntary by physical or chemical hired to treat the limited to treat the limited to treat the liscipline or convenience required to treat the list the list that the li					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155778		l í	JILDING	nstruction 00	(X3) DATE COMPL 09/16/	ETED	
	PROVIDER OR SUPPLIER			1212 E	ADDRESS, CITY, STATE, ZIP CODE MAIN A, IN 47918		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	abuse, neglect, a residents and miresident property procedures to invallegations, and policies and procedures are altered to treat symptoms. Responding physical integral and procedure are and any physical required to treat symptoms. Responding physical integral and procedure are appropriation.	icy titled "Abuse orting, and Investigation edure" provided by the a 9/14/17 at 11:30 a.m., is not limited to: "Policy: If Parkview Healthcare to ents from abuse, neglect, in of resident property, This includes but is not im from corporal coluntary selection [sic] or chemical restraint not the resident's medical consibility: All Staff use - the willful infliction onable confinement,					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155778	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/16/2017			
NAME OF PROVIDER OR SUPPLIER PARKVIEW HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being8. All abuse allegations must be reported to the Administrator immediately and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action; up to and including immediate termination. 9. The Administrator is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations and for assuring that all policies and procedures are followed" The immediate jeopardy that began on 9/6/17 was removed on 9/16/17 when the facility inserviced all regular staff on the policies and procedures for abuse prohibition policies, and expanded the investigation of the allegation to include night shift staff members. Employee files were audited for current license, background checks, and completed references. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility need for continued monitoring. This federal tag is related to complaint						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/16/2017			
NAME OF PROVIDER OR SUPPLIER PARKVIEW HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	IN0029907. 3.1-28(c) 3.1-28(d)								

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