CENTERS FOR	R MEDICARE & MEDIC				_	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155746		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		B. WING		12/28/	12/28/2023	
NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN			STREET. 101 CC FRANC	<u> </u>		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 0000	REGUETITORI GI	CESCIDENTI TING IN CREATITION	1710			Ditte
F 0000 Bldg. 00	IN00423481 and IN COVID-19 Focused Complaint IN00423 related to the allegal F609. Complaint IN00424 the allegations are of Survey dates: Dece Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 30 Residential: 21 Total: 51 Census Payor Type Medicare: 2 Medicaid: 11 Other: 17 Total: 30	ember 27 & 28, 2023 20539 155746 267280 : : reflect State Findings cited in 0 IAC 16.2-3.1.	F 0000	Parkview Haven respectfully requests a desk review for compliance based on the low scope and severity.		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse a §483.12 Freedom Exploitation	and Neglect from Abuse, Neglect, and				

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

TITLE (X6) DATE

Max Wayern Jones Administrator 01/17/2024

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/28/2023 155746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 CONSTITUTION DR PARKVIEW HAVEN FRANCESVILLE, IN 47946 (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 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. 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 medical symptoms. §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; F 0600 01/18/2024 TAG # F600 - Freedom from Based on observation, record review, and Abuse, Neglect, and interview, the facility failed to ensure a resident **Exploitation** was free from verbal and physical abuse, related What corrective action(s) to a staff member's forceful attempts to pry a will be accomplished for those resident's hand open, pressing their fingers into residents found to have been the resident's neck, and yelling foul language at affected by the deficient the resident, for 1 of 2 residents reviewed for practice: abuse. (Resident B and Terminated Employee 1) Resident B was immediately separated from Terminated Finding includes: Employee #1 by direct care giver to ensure safety. Family/POA, Resident B was interviewed on 12/27/23 at 9:13 attending physician, executive a.m. She indicated an Employee had given her director, and director of nursing medications and she had not wanted to take them. were notified. Resident B The Employee kept "pushing me to take them" assessment was conducted, no and I wanted to know what they were. The injuries noted at that time. Employee cussed at her and said they were going Resident B stated she feels safe to make me take them. She had a glass of water in in the facility. her hand and threw it at the Employee so they Terminated Employee #1 was would leave her alone. They then put their thumb immediately notified via phone by up to her neck and pressed hard into her neck. executive director and director of She demonstrated what was done. The nursing that they were observation indicated the Employee's thumb and immediately suspended for an forefinger was in the front/left middle area of the allegation of abuse. neck and was pressing into the skin. She indicated

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155746 B. WING 12/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 CONSTITUTION DR PARKVIEW HAVEN FRANCESVILLE, IN 47946 (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 they had pressed hard and it hurt. She then, "got How other residents having away from" them and reported the incident. The the potential to be affected by Police come in and the Employee can no longer the same deficient practice will come into the building. be identified and what corrective action(s) will be An Indiana Department of Health (IDOH) reported taken: incident, dated 12/6/23 at 12 p.m., indicated on All residents have the 12/6/23 at 5:01 a.m., Resident B was treated potential to be affected by this inappropriately by Terminated Employee 1. The deficient practice. Terminated Employee 1 was immediately suspended and the incident was under 3 What measures will be put investigation. into place and what systemic changes will be made to The follow-up to the IDOH reported incident, ensure that the deficient dated 12/11/23, indicated the Resident alleged that practice does not recur; the staff member made contact with her neck and a Education provided regarding arm after she had refused her medications and she F-Tag #600- all residents will be had tossed water in the employee's face. free from abuse, neglect, & Terminated Employee 1 was interviewed and exploitation. indicated they had grabbed the front of the resident's clothing, and not her neck area, and had How the correct action(s) held her arm to keep her from falling. Staff will be monitored to ensure the members working at the time were interviewed and deficient practice will not one staff member indicated she heard yelling recur; i.e.; what quality though did not know what had happened. assurance program will be put Another staff member stated she immediately into place; separated the employee and the resident. Several Director of Nursing/Social residents were interviewed and indicated they Services/Designee will provide heard loud speaking though were unable to hear in-services to all team members what was being said. The local police were on abuse, neglect, & exploitation notified. There had been no evidence of injury to monthly x 3 months, quarterly the resident. The allegation of abuse was thereafter x 3 quarters, PRN as substantiated and the Employee was terminated. needed and upon hire to ensure compliance. Resident B's record was reviewed on 12/27/23 at Results will be reported to the 11:33 a.m. The diagnoses included, but were not monthly QAPI meeting for review. limited to, Alzheimer's disease. After reviewing results, an action plan may be developed, if needed, A Quarterly Minimum Data Set assessment, dated to ensure compliance. 11/21/23, indicated a moderately impaired

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPLETED	
155746		B. WI	ING		12/28/2	2023	
NAME OF T	DOMDED OF GUEST IS:	,		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIEF	A		1	NSTITUTION DR		
PARKVIE	EW HAVEN		_	FRANC	ESVILLE, IN 47946		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	d no behaviors, and was			5 By what date the system		
	independent for am	bulation.			changes for each deficient v	will	
		N			be completed.		
	_	Note, dated 12/6/23 at 12:44			a January 18, 2024		
	1 ~	had made an allegation of					
		ropriately by a staff member.					
		completed and there was no					
		ation of the skin not completed					
		edness or discoloration of the e was no acute distress noted.					
	skin noted and ther	e was no acute distress noted.					
	A Nurse's Progress note, dated 12/6/23 at 4:40						
	p.m., indicated she	was calm and was in no					
	distress.						
		6 d t t = 55					
	_	from the Assistant Director of					
		dated 12/6/23 and not time					
		ated Employee 3 asked her to					
		The resident had been talking					
		ut an incident that occurred. ted Terminated Employee 1					
		ted Terminated Employee Therefor not taking her					
	_	ey had argued back and forth					
		e threw a glass of water in his					
		he then pressed his thumb into					
		sked him if he was trying to kill					
		d screaming and he walked					
		no marks on the resident's neck					
		ry. She was calm during the					
		ninistrator was then alerted.					
		yee 1 was interviewed by the					
		at approximately 2:30 p.m. per					
		idicated the resident's					
		placed on her walker seat and he					
		from the resident. She then					
		medication and he attempted					
		ons back to destroy them. She					
		medications back and					
l	"eventually" threw a cup of water in his face. He		1	l			

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

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155746		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/28/2023	
NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN			STREET ADDRESS, CITY, STATE, ZIP COD 101 CONSTITUTION DR FRANCESVILLE, IN 47946				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)		TE	(X5) COMPLETION DATE
	at her. She no longe and he held her arm	sident by the shirt and yelled er had her hands on the walker to get her to hold onto the 2 then intervened and he walked					
	Employee 2's writte statement, indicated Employee 1 had sta Resident B had exit and indicated the remood. Employee 4 conversation with t Employee 1 set a si medication cup wit and walked away. I from the resident. T ambulate towards h the medication cart was standing. Employee the medication cart was standing. Employee the medication cart was standing. Employee in the medication cart was standing. Employee in the medication cart was provided that said, the was not going to "give me the f**** to pry her hand ope medications clench	en, non-dated and non-signed around 4:30 a.m., Terminated arted the medication pass. Seed her room with her walker esident was not in a good had attempted to have a he resident and Terminated mall plastic cup of water and a him medications on her walker Employee 4 then walked away the resident had started to the room and she stopped by where Terminated Employee 1 doyee 2 was unsure what the then Terminated Employee 1 stations back from the resident if to take them. He then yelled, ** meds" He was attempting in because she had the					
	then pushed her aga hand up under her of "stop being so f*** Employee 2 then ju the he let go of the rubbing her neck ar stupid idiot". The to continued yelling a Employee 1 was wayou" repeatedly. The to her room and the then got dressed. We	water and threw it at him. He minst the wall and had one whin. He was yelling at her to, *** mean and hateful." mped up and said, "hey" and resident. The resident was ad said, "you hurt me, you wo were separated. They t each other. Terminated alking away and yelling, "F*** the resident was assisted back in took the medications. She when the Day Shift staff came teed talking to Employee 3.					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
155746		B. WING		12/28/2023		
	PROVIDER OR SUPPLIER		101 CC	ADDRESS, CITY, STATE, ZIP COD DNSTITUTION DR CESVILLE, IN 47946		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S BLAN OF CODDECTION	(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	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Employee 4 was int approximately 10:30 indicated around 5:30 She was in another to the bathroom. Af she noticed water or Station. Residents G, H, and close to where the ininterviewed on 12/6 yelling in the hallwas being said. During a telephone p.m., Employee 2 in been in a good moo Terminated Employ with medications in them on the seat of ambulating toward asked the him what she was informed it medication cup was looked up and obser the medication out of saying "f***** given the resident's neck a wall. The resident's neck a wall. The resident's neck a wall. The resident's neck a wall was attempting to employee. Employee.	derviewed on 12/6/23 at 00 a.m. by telephone, and 30 a.m. she had heard yelling. resident's room assisting them after she completed the care, in the floor by the Nurses' 1 J, who resided on the hallway incident occurred, were 5/23. They indicated they heard ay. They were unsure what was interview on 12/27/23 at 6:20 indicated Resident B had not did the morning of 12/6/23. It is a provided and a glass of water and sat the walker. The resident was their room and she stopped and was in her medication cup and was her medications. The sin her hand. Employee 2 then rived him attempting to "pry" of the resident hands and was we them back", the resident ter on him. He then grabbed and had her back against the tarted yelling, "you hurt my did back, "f*** you". Employee separate the resident and the see 2 was trying to talk to the nated Employee 1 was yelling				
	Employee 4 indicate	on 12/28/23 at 11:02 a.m., ed Resident B had not been in 6/23. She had been talking to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155746		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/28/2023					
	PROVIDER OR SUPPLIER	2	101 CC	STREET ADDRESS, CITY, STATE, ZIP COD 101 CONSTITUTION DR FRANCESVILLE, IN 47946					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	D BE COMPLETION				
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
		erminated Employee 1 placed							
		the resident's walker. A call ated down the hall. She							
	_	ll light and assisted that							
	_	throom. She was unable to							
		g said but could hear yelling in							
		he care had been completed,							
	-	on the floor and was told by							
		vee 1 that Resident B had							
	thrown water at him	1.							
	During an interview on 12/28/23 at 11:08 a.m., the ADON indicated Employee 3 had asked her to talk to Resident B on 12/6/23 around 6:35 a.m. She had been told the resident was making some "weird"								
		ent had informed her she had							
		ated Employee 1 and had							
		face. He had gotten mad and							
	put his hands aroun	-							
	_	peen notified by text around							
	8:45 a.m. on 12/6/2	3.							
	A facility Abuse Po	olicy, received from the DON as							
	-	2017, indicated the resident has							
		verbal and physical abuse and							
	must not be subject	ed to abuse by anyone.							
	This citation relates	to Complaint IN00423481.							
	3.1-27(a)(1)								
	3.1-27(b)								
F 0609	483.12(b)(5)(i)(A)(
SS=D	Reporting of Alleg								
Bldg. 00	- , ,	oonse to allegations of							
	_	cploitation, or mistreatment,							
	the facility must:								
	8483 12(c)(1) Enc	sure that all alleged							
	violations involving								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155746	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/28/2023			
NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN			101 CC	STREET ADDRESS, CITY, STATE, ZIP COD 101 CONSTITUTION DR FRANCESVILLE, IN 47946				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
	exploitation or misinjuries of unknown misappropriation or reported immedia hours after the allevents that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established systems and administrator of the designated resulting to the State of the officials in accordincluding to the State of the officials in according and administrator of the related to a staff to of 2 residents revier Terminated Employ Finding includes: An Indiana Departrincident, dated 12/6/23 at 5:01 a.m. inappropriately by the state of the surface of the surfac	streatment, including on source and of resident property, are tely, but not later than 2 egation is made, if the other allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the facility and to other into the State Survey protective services where is for jurisdiction in long-term accordance with State law end procedures. Foort the results of all the administrator or his or presentative and to other ance with State law, the incident, and if the incident, and if the incident, and if the incident, and if the services and interview, the facility allegation of abuse to the efacility, in a timely manner, resident abuse allegation, for 1 wed for abuse. (Resident B and	F 0609	TAG # F609 – Reporting of Alleged Violations 1 What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice; a Resident B was immediate separated from Terminated Employee #1 by direct care give to ensure safety. Family/POA, attending physician, executive director, and director of nursin were notified. Resident B	01/18/2024) se n ely ver			

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suspended and the incident was under

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 ${\it Facility ID:} \quad 000539$

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assessment was conducted, no

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPLETED	
15		155746	B. W	B. WING		12/28/2023	
				CTPEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF				NSTITUTION DR		
	EW HAVEN						
FARNVI	EVV FAVEIN			FRANC	CESVILLE, IN 47946		
(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 COM	PLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		ATE
	investigation.				injuries noted at that time.		
					Resident B stated she feels sa	afe	
	The follow-up to th	e IDOH reported incident,			in the facility.		
	dated 12/11/23, ind	icated the Resident alleged that			b Terminated Employee #1	was	
	the staff member m	ade contact with her neck and			immediately notified via phone	by by	
	arm after she had re	fused her medications and she			executive director and director	of	
	had tossed water in	the employee's face.			nursing that they were		
	Terminated Employ	vee 1 was interviewed and			immediately suspended for an	ı	
	indicated they had g	grabbed the front of the			allegation of abuse.		
	resident's clothing,	and not her neck area and had					
	held her arm to kee	p her from falling. Staff			2 How other residents hav	ing	
	members working a	at the time were interviewed and			the potential to be affected b	y	
	one staff member ir	ndicated she heard yelling			the same deficient practice v	vill	
	though did not know	w what had happened.			be identified and what		
	Another staff memb	per stated she immediately			corrective action(s) will be		
	separated the emplo	yee and the resident. Several			taken;		
	residents were inter	viewed and indicated they		a All residents have the			
	heard loud speaking	g though were unable to hear			potential to be affected by this		
	what was being said	d. The local police were			deficient practice.		
	notified. There had	been no evidence of injury to					
	the resident. The all	legation of abuse was			3 What measures will be p	ut	
	substantiated and th	e Employee was terminated.			into place and what systemic	;	
					changes will be made to		
	Cross reference F60	00.			ensure that the deficient		
					practice does not recur;		
	Employee 2's writte	en, non-dated and non-signed			a Education provided regard	ding	
	statement, indicated	l around 4:30 a.m., Terminated			F-Tag #609- Timely reporting	of	
	Employee 1 had sta	rted the medication pass.			alleged violations.		
	Resident B had exit	ed her room with her walker					
	and indicated the re	sident was not in a good			4 How the correct action(s)	
	mood. Employee 4	had attempted to have a			will be monitored to ensure t	he	
	conversation with the	ne resident and Terminated			deficient practice will not		
	Employee 1 set a sr	nall plastic cup of water and a			recur; i.e.; what quality		
	medication cup with	n medications on her walker			assurance program will be p	ut	
	and walked away. H	Employee 4 then walked away			into place;		
	from the resident. T	he resident had started to			a Director of Nursing/Social		
	ambulate towards h	er room and she stopped by			Services/Designee will provide	e	
	the medication cart	where Terminated Employee 1			in-services to all team membe	rs	
	was standing. Empl	oyee 2 was unsure what the			on reporting of alleged violation	ns	
	resident had said, th	nen Terminated Employee 1			monthly x 3 months, quarterly		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	a. building <u>00</u>		COMPLETED	
155746		B. W	B. WING 12/28/2023			2023	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			NSTITUTION DR		
PARKVIF	EW HAVEN				ESVILLE, IN 47946		
	T		-		,	1	
(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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ations back from the resident if			thereafter x 3 quarters, PRN a		
		o take them. He then yelled,			needed and upon hire to ensu	ire	
	_	** meds" He was attempting			compliance.		
		n because she had the ed in her hand. She then			b Results will be reported to		
		water and threw it at him. He			monthly QAPI meeting for revi		
	, ,	inst the wall and had one			After reviewing results, an act		
		thin. He was yelling at her to,			plan may be developed, if nee	:ueu,	
		*** mean and hateful."			to ensure compliance.		
		mped up and said, "hey" and			5 By what date the system	,	
		dent. The resident was rubbing			changes for each deficient w		
		you hurt me, you stupid			be completed.	''''	
		e separated. They continued			a January 18, 2024		
		r. Terminated Employee 1 was			a canaary 10, 2021		
		velling, "F*** you" repeatedly.					
		sisted back to her room and					
		eations. She then got dressed.					
		t staff came in, the resident					
	started talking to Er						
	Employee 2 was int	terviewed by telephone on					
	12/27/23 at 6:20 p.r	n. and indicated Resident B had					
	not been in a good i	mood the morning of 12/6/23.					
	Terminated Employ	vee 1 brought a medication cup					
	with medications in	it and a glass of water and sat					
		the walker. The resident was					
		her room and she stopped and					
		was in her medication cup and					
		was her medications. The					
		s in her hand. Employee 2 then					
	_	rved him attempting to "pry"					
		of the resident hands and was					
		ve them back", the resident					
	_	ter on him. He then grabbed					
		and had her back against the					
		tarted yelling, "you hurt my					
		d back, "f*** you". Employee					
		separate the resident and the					
		ee 2 was trying to talk to the					
	resident and Terminated Employee 1 was yelling						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FXCP11 Facility ID: 000539

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

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155746		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/28/2023			
NAME OF PROVIDER OR SUPPLIER PARKVIEW HAVEN			STREET ADDRESS, CITY, STATE, ZIP COD 101 CONSTITUTION DR FRANCESVILLE, IN 47946					
PARKVIE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF at her in the hall, "f had not notified the of Nursing after the During an interview Administrator indic the allegation in a t have been called by telephone number i During an interview ADON (Assistant I Employee 3 had asl 12/6/23 around 6:3: resident was makin resident had inform Terminated Employ	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION *** you". She indicated she Administrator or the Director incident had occurred. y on 12/28/23 at 10:31 a.m., the rated he was not made aware of imely manner and he should y Employee 2. He indicated he s posted at the Nurses' Desk. y on 12/28/23 at 11:08 a.m., the Director of Nursing) indicated ked her to talk to Resident B on 5 a.m. She had been told the g some "weird" remarks. The ed her she had words with yee 1 and had thrown water in		FRANC ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	his face. He had go around her throat. T notified by text arou The facility Abuse as current, and date allegations were to Administrator.	tten mad and put his hands The Administrator was then und 8:45 a.m. on 12/6/23. Policy, received from the DON d 2017, indicated abuse be reported immediately to the s to Complaint IN00423481.						

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