STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155516	A. BUILDING 00 B. WING	12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MEMORIAL HOSPITAL-CCC	2200 RANDALLIA DR FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00212940, IN00214417 and IN00215167. Complaint IN00212940 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241 and F315 Complaint IN00214417- Unsubstantiated due to lack of evidence. Complaint IN00215167- Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 29, 30, 2016 and December 1, and 2, 2016. Facility number: 001203 Provider number: 155516 AIM number: n/a Census bed type: SNF: 29 Total: 29 Census payor type: Medicare: 15 Medicaid: 01 Other: 13 Total: 29	F 0000		

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

Any defiencystatement 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.

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	Sample: 09 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 29081 on December 5, 2016.			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, record review and interviews, the facility failed to ensure 2 of 3 residents reviewed for dining and eating needs received timely assistance with meal set up and assistance. (Residents C and E) Findings include: 1. During the initial tour of the facility, conducted on 11/29/16 between 12:30 P.M. - 1:20 P.M. with the Unit leader,	F 0241	It is the practice of this facility to provide identified patients with required assistance with toileting needs and incontinence care. Patient in question was assisted with incontinence care. Nursing staff will be educated on individualized care plan for patients with focus on bladder incontinence. Education will be done at huddles and roaming in-services. Director of Nursing will assure nursing staff received education by 12/31/16 by utilizing a sign in log for staff. Policy	12/31/2016

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	RN #1, Resident #C was identified as very confused, required extensive staff assistance for activities of daily living, primarily stayed in bed, liked to be fed by staff but could feed herself but required supervision, and had been admitted from home and had a diagnosis of "failure to thrive." Resident C was observed in her bed, dressed in a hospital gown and looked disheveled. She was animated and conversive but her conversation was illogical and nonsensical. On 11/30/16 at 12:30 P.M., Resident C was observed in her room in her bed. Her meal tray was in front of her on an overbed table. There was a small can of soda, unopened, a 1/2 sandwich in a clear plastic container, unopened, a small bowl of fresh fruit in a clear dish, covered with a lid and unopened, and a bowl of soup in a Styrofoam bowl. The resident was holding a plastic bag with a fork and knife in the bag. She then put down the silverware bag and picked up her bowl and drank her soup. She talked nonsensically about a black bag being taken away. She did not attempt to open any of the other food items and there were no staff in the room. At 12:45 P.M., Resident C was again observed in her room in her bed. She drank some more of her soup but the rest of her meal remained unopened.		"Bladder Evaluation and Training" will be reviewed by DON and Administrator. All patients have the potential to be affected by this practice. Changes in monitoring of incontinent status for those patients who are new admissions, and any change in voiding will be reviewed to ensure a 3 day monitoring of voiding is completed and any change in pattern will be reviewed by DON/Designee. MD/NP will be notified for any significant changes in voiding pattern. Care plans will be updated and reviewed for necessary changes as needed. Nursing staff education started at huddles and roaming in-services on individualized care planning for residents with focus on incontinent patients. The DON/Designee will review 3 day bladder record for all new admits and designated rooms until all resident's care plans are reviewed. The MDS/Designee will weekly monitor all residents' incontinence status by utilizing the nursing staff voiding charting in the computer system. Any significant changes in voiding pattern the DON/Designee will review and notify MD/NP if needed. The DON will assure nursing staff education on individualized care planning will be completed by 12/31/16 by utilizing a sign in log for staff.	

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	On 12/01/16 at 12:12 P.M., Resident C's meal tray was delivered by dietary staff and placed on the overbed table beside her bed. Resident C was in her bed asleep and was not awakened or her meal placed in her reach and set up for her. Her meal tray remained untouched in her room and she remained sleeping until 12:23 P.M., when CNA #2 went into her room, woke her up and set up her food for her. Resident C then began to feed herself. On 12/01/16 at 12:30 P.M., LPN #3 was overheard asking when and who had delivered the meal tray to Resident C as she needed assistance and nursing staff were to be notified when the meal trays were delivered to resident that needed assistance. The clinical record for Resident #C was reviewed on 11/30/16 at 9:10 A.M. Resident C was admitted to the facility on 09/08/16 with diagnoses, including but not limited to: anxiety, delirium, malnutrition and adult failure to thrive. The initial Minimum Data Set (MDS) assessment for Resident C, completed on 09/15/16 indicated the resident required supervision and set up assistance for eating needs. The care plan related to		To ensure compliance, the DON/Designee will review monitoring tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Completion Date: 12/31/16 We are asking for you to consider a desk review for this complaint.	

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	cognitive dysfunction, initiated on 11/01/16 included an intervention to assist the resident with ADL's. (Activities of daily living) A care plan related to food and/or nutrient delivery included an intervention for feeding assistance. A plan related to nutritional status, initiated on 11/29/16 included an intervention to assist the patient with eating. 2. During the initial tour of the facility, conducted on 11/29/16 between 12:30 P.M. - 1:20 P.M. with the Unit leader, RN #1, Resident E was observed lying in her bed, dressed in a hospital gown with oxygen tubing per nasal cannula. The resident was noted to be very thin in stature. RN #1 indicated Resident E was confused, could feed herself but would get distracted, required extensive staff assistance for ADL's, and had fallen at home prior to being admitted to the acute care facility. On 11/30/16 at 12:30 P.M., Resident E was noted to have a meal tray on the overbed table in front of her. The resident had drank a pink colored liquid from a cup with a lid and straw but indicated she could not feed herself and needed help. No staff were noted in the room. At the resident's request, CNA #4 was notified of Resident E's request. CNA #4 indicated Resident E was			

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	supposed to feed herself. CNA #4 entered the room and stood beside and slightly behind Resident E and fed her a bite of her food. At 1:15 P.M., Resident E's meal tray was noted to have been moved across the room on a counter. Resident E's husband was in the room and indicated he had fed Resident E but she had not eaten very much. On 12/01/16 at 11:55 A.M., Resident E was noted in her room in her wheelchair with her meal tray on an overbed table in front of her. The resident was holding a clear plastic up with a pink liquid and had drank most of the liquid. The resident's cottage cheese and fruit bowl and a yellow colored pudding type food item were untouched and her silverware was still wrapped in a napkin on her tray. At 12:12 P.M., Resident E activated her call light. At 12:15 P.M., a dietary staff member answered the call light and Resident E told her she needed help to eat her meal. The dietary staff member then stood and fed Resident E a bite of her cottage cheese and then left the resident's room and alerted a nursing staff member of Resident E's need for assistance. At 12:20 P.M., a nurse then went into Resident E's room and stood to feed her lunch. Both the dietary and nursing staff members stood beside and over the resident while feeding her.			

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	The facility policy and procedure, titled "Nutrition Services", undated but provided by the Director of Nursing on 12/01/16 at 3:27 P.M. included the following: "...13. Meal trays will be delivered to the Continuing Care Center by the Nutrition and Dining Service Department. Dietary staff will deliver the tray to the resident. Nursing staff will assist the resident and/or prepare the tray, if indicated, and assist with feeding where necessary...." There were no procedures to indicate any time frame for setting up or assist those residents that required assistance. In addition, there was no procedure for ensure staff were seated at eye level while providing feeding assistance. This Federal tag is related to IN00212940. 3.1-3(t)			
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on			

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	admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review and interviews, the facility failed to ensure the bladder incontinence of 1 of 3 residents reviewed for toileting needs was thoroughly assessed and the care plan followed to restore as much bladder continence as possible. (Resident #C)	F 0315	I placed the F315 in the F241 deficiency. We are asking for you to consider a desk review for this complaint. **F241** It is the practice of this facility to provide all patients meal set up and assistance if needed in a timely manner.	12/31/2016

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	Finding includes: During the initial tour of the facility, conducted on 11/29/16 between 12:30 P.M. - 1:20 P.M. with the Unit leader, RN #1, Resident #C was identified as very confused, required extensive staff assistance for activities of daily living, primarily stayed in bed, was incontinent of her bowels and bladder and had been admitted from home and had a diagnosis of "failure to thrive." Resident C was observed in her bed, dressed in a hospital gown and looked disheveled. She was animated and conversive but her conversation was illogical and nonsensical. The initial Minimum Data Set (MDS) assessment for Resident C, completed on 09/15/16 indicated the resident required extensive staff assistance for bed mobility, personal hygiene and toileting needs. The resident was occasionally incontinent of her bladder. The current health care plan related to "Bladder/Voiding" included the following interventions: "Initiate bladder program, encourage voiding, monitor intake and output, encourage patient to identify medication that aid bladden (sic), utilize bladder scans prior to or post void		Patient in question was assisted with her meal. Nursing staff will be educated on delivery of meal tray for patients requiring assistance. Director of Nursing will assure nursing staff received education on meal assistance and tray setup by 12/31/16 at huddles and roaming in-services. Policies on “Room Service” and “Tray Delivery” will be reviewed by DON and Administrator. All patients have the potential to be affected by this practice. All new admits and current patients will have monitoring tool in place to help identify those patients who need meal tray setup, and those who need assistance with meals. Education will be provided at huddles and roaming in-services on meal assistance and tray setup this will be completed by DON/Designee by 12/31/16. MD/NP will be notified for any significant changes in assistance with meals. Care plans will be updated and reviewed for necessary changes as needed. Nursing staff and dietary staff will be educated on meal assistance and tray setup. A red silverware picture magnet will be placed on the outside of the doors by nursing staff to identify patients that require assistance. Before the tray is delivered, the dietary host will notify nursing staff before leaving the meal tray. The DON/Designee will review record for all new admits and current patients to ensure any patient	

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	to an appropre (sic), ambulate patient to the bathroom with appropriate assistive device, teach patient to call for help when getting up to use the toilet, educate family and patient on bladder program/schedule, educate patient about medications, educate patient on appropriate volumes for intake and output." In addition there were goals to "encourage intermittent catherization." Resident C was observed on 11/30/16 from 8:50 A.M. - 10:50 A.M., lying in her bed, dressed in a hospital gown awake. Nursing staff had been in her room at different times but she was not observed to have been toileted and/or checked for incontinence or changed. At 10:50 A.M., she was noted talking in her room and indicated she was not doing well and had been calling and calling for help but no one would come help her. The resident's call light was not activated and while she was noted to be talking in her room, her voice was not really audible in the hallway outside her room. Resident C indicated she had "tinkled all over." CNA #5 was notified and she was noted to change Resident C's bed, bed pad and provided peri care and dressed the resident in a clean gown. The resident's sheet, pad, and gown were noted to be wet and soiled with a yellow colored stain. CNA #5 indicated		requiring assistance is assisted with meal. Director of Nursing will assure nursing and dietary staff received education by 12/31/16 by utilizing a sign in log for staff. To ensure compliance, the DON/Designee will review monitoring tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. MD/NP will be notified for any significant changes in assistance with meals. Any identified trends will be forwarded to the Administrator for review and presented to QA to determine further educational needs. Completion Date: 12/31/16	

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	Resident C did not ambulate and was just checked for incontinence and changed. Resident C was observed on 12/01/16 from 8:45 A.M. - 10:25 A.M., lying in her bed. She was dressed in a purple colored shirt she had worn the previous day and the shirt was soiled with a white colored food smear on the chest. The resident's hair was uncombed and greasy looking. At 10:25 A.M., CNA #2 and a nursing student entered the room to provide a bed bath to Resident C. During an interview with CNA #2 she indicated Resident C refused to be showered, occasionally could be talked into getting out of bed into her wheelchair, and did not use the toilet but was checked and changed for incontinence. She indicated there was no schedule for toileting Resident C. On 12/01/16 at 11:30 A.M., CNA #2 and LPN #3 were observed to transfer Resident C from her wheelchair back into her bed. The resident did not follow instructions, was slightly resistant to the use of a gait belt, and required both staff members to provide total lifting assistance to complete the transfer. The staff members then changed the resident's incontinence brief. The resident was not provided with an opportunity to use the toilet or a bedpan.			

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	During an interview with the MDS coordinator, RN #6, on 12/01/16 at 3:30 P.M. she indicated the nursing staff completed a head to toe assessment on admission to the continuing care center. She provided the assessment for Resident C, completed on 09/08/06, which indicated she was both incontinent and continent of her bladder. There was no further assessment information regarding Resident C's bladder incontinence. During an interview with the Director of Nursing, on 12/01/16 at 3:32 P.M. she indicated Resident C had declined cognitively which had affected her bladder continency. The DON indicated the resident had previously been using a bed pan for voiding but more recently had just been checked and changed. She confirmed the resident had not utilized the toilet since she had been at the facility. The facility policy and procedure, titled, "Bladder Evaluation and Training", undated and provided by the DON on 12/01/16 at 2:40 A.M. included the following procedures: "...1. Nurse will initiate a bladder diary for at least five days with all nursing staff recording the pattern of voiding, incontinent episodes and reasons for incontinent episodes...3. The Resident Care Coordinator will, if			

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	indicated, determine a bladder-emptying schedule through the use of toileting to avoid incontinent episodes. Voiding every two hours is a schedule that ay be utilized if no pattern can be established to avoid incontinent episodes. 4. Resident care plan will include provisions for maximum independent in maintaining continence. When appropriate, toileting will be done by staff (with incontinence record kept on all shifts) on an individualized schedule with provision of incontinent brief if needed...." This Federal tag is related to IN00212940. 3.1-41(a)(2)			