PRINTED: 12/18/2023
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		A. BUILDING	00	COMPLETED 11/20/2023	
		B. WING			
		100010			11/20/2020
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
IVALUE OF I	ROVIDER OR BOTTELL	N.	1001 N	GRANT ST	
SIGNATI	JRE HEALTHCARI	E AT PARKWOOD	LEBAN	ION, IN 46052	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
Diag. 00	This visit was for t	he Investigation of Complaints	F 0000	This Plan of Correction is the	
		-	F 0000		
		421018, IN00418784 and		center's credible allegation of	
	IN00415176.			compliance.	
	_	1376 - No deficiencies related to		Preparation and/or execution	
	the allegations are	cited.		this plan of correction does no	ot
				constitute admission or agree	ment
	Complaint IN0042	1018 - No deficiencies related to		by the provider of the truth of	the
	the allegations are			facts alleged or conclusions s	et
				forth in the statement of	
	Complaint IN0041	8784 - Federal/state deficiencies	deficiencies. The plan of		
	related to the allegations are cited at F580.			correction is prepared and/or	
	l'elated to the unego	ations are cited at 1 500.		executed solely because it is	
	Commissint INIO041	5176 - Federal/state deficiencies		-	
	-			required by the provisions of	
	related to the allega	ations are cited at F580.		federal and state law.	
	G 1. N	1 17 120 2022			
	Survey dates: Nove	ember 17 and 20, 2023.			
	F 11: 1 0/	00460			
	Facility number: 00				
	Provider number: 1				
	AIM number: 1002	290270			
	Census Bed Type:				
	SNF/NF: 73				
	Total: 73				
	Census Payor Type	e:			
	Medicare: 2				
	Medicaid: 56				
	Other: 15				
	Total: 73				
	10111. 75				
	This definionary and	lects State Findings cited in			
	accordance with 41				
	accordance with 41	10 IAC 10.2-3.1.			
	0.10	1.1.1.20			
		s completed on November 28,			
	2023.				
	i company and a second a second and a second a second and			1	

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

TITLE (X6) DATE

Jennifer Hurt Administrator 12/13/2023

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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	te survey ipleted 20/2023				
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			1001 N	STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must in resident; consult we physician; and not her authority, the rewhen there is- (A) An accident interesults in injury and requiring physician (B) A significant of physical, mental, of (that is, a deterioral psychosocial status conditions or clinic (C) A need to alter (that is, a need to form of treatment); or (D) A decision to the resident from the form (g)(14)(i) of this seensure that all per in §483.15(c)(2) is upon request to the (iii) The facility multiple resident and the reany, when there is (A) A change in reassignment as specific (B) A change in reassignment as specific (B) A change in reassignment (e)(10) (iv) The facility multiple resident in the facility multiple resident in the reassignment as specific (B) A change in reassignment as specific (B) A change in reassignment (e)(10) (iv) The facility multiple resident in the facility	(Injury/Decline/Room, etc.) stification of Changes. mmediately inform the with the resident's ify, consistent with his or resident representative(s) volving the resident which d has the potential for intervention; nange in the resident's or psychosocial status ation in health, mental, or is in either life-threatening cal complications); retreatment significantly discontinue an existing due to adverse to commence a new form ransfer or discharge the racility as specified in notification under paragraph ection, the facility must tinent information specified available and provided e physician. st also promptly notify the esident representative, if incom or roommate ecified in §483.10(e)(6); or sident rights under Federal gulations as specified in of this section. est record and periodically s (mailing and email) and							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPI			LETED	
		155378	B. W	ING		11/20	/2023
NAME OF T	DDOMDED OF CURPY TEX			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	K		1001 N	GRANT ST		
SIGNATU	JRE HEALTHCARE	E AT PARKWOOD		LEBAN	ON, IN 46052		
(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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	representative(s).						
	§483.10(g)(15)						
		emposite distinct part. A					
		omposite distinct part (as					
	1) must disclose in its					
	admission agreen	•					
	_	uding the various locations					
	_	composite distinct part,					
		the policies that apply to					
	_	tween its different locations					
	under §483.15(c)(` ,					
		and record review, the facility	F 0:	580	F580: Medications non-available		12/13/2023
	1	responsible party/Power of			1 How the corrective actio		
		nen a new order for an			will be accomplished for those		
		received and administered and			residents found to be affected	by	
		physician when medications			the deficient practice:		
		or administration for 2 of 3			Residents B and C were	:4-	
	(Resident B and C)	for notification of changes.			discharged from the facility pri	IOF (O	
	(Resident B and C)				survey.		
	Findings include:				2 How will the facility ident	tify	
					other residents having the		
		one interview, on 11/17/23 at			potential to be affected by the		
		ponsible party/POA for Resident			same deficient practice:		
		s not notified of a new order			On 12/8/2023, the Director of	-4	
		(an antipsychotic) nor was she			Nursing (DON), Assistant Dire		
	informed of the adn	ministration of the medication.			of Nursing (ADON), Transition		
	The record for Pasi	ident B was reviewed on			Care Nurse (TCN) and the Sta Development Coordinator (SE		
		o.m. Diagnoses included, but			pulled the eMAR administration	•	
	_	, dementia, chronic obstructive			compliance report to identify a		
	pulmonary disease,				other residents with medication	-	
	r minerally disease,				documented as "medication n		
	A physician's order	, dated 4/17/23, indicated to			available." There was 1 reside		
	1 * *	5 milligrams to one milliliter one			the report. The DON, ADON,		
		on was administered on 4/17/23			and SDC audited to ensure al		
		was no notification to the			medications were available pe		
	•	OA of the new order or the			their physician orders.		
	administration of th				Medications that were not		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPL	ETED
		B. W.	ING		11/20/	/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			GRANT ST		
SIGNATURE HEALTHCARE AT PARKWOOD				LEBAN	ION, IN 46052		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	N OF CORRECTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					available were called in to the		
	A physician's order	r, dated 4/25/23, indicated to			pharmacy for stat delivery.		
	give Haldol lactate	5 milligrams to one milliliter					
	STAT (immediatel	y). The medication was			3 What measures will be p	out	
	administered on 4/2	25/23. There was no notification			into place or what systemic		
	to the responsible p	party/POA of the new order or			changes the facility will make	to	
	the administration				ensure the deficient practice of		
					not recur:		
	During an interview	w, on 11/20/23 at 3:13 p.m., the			On 12/8/2023, the DON provide	ded	
	Director of Nursing	g indicated the facility did not			education to the ADON, SDC		
	have documentatio	n to show the responsible			TCN on pulling the following		
	party/POA had bee	en notified of two new STAT			reports in MatrixCare, eMAR		
	(immediate) orders	for Haldol, nor did the facility			administration compliance,		
	have documentatio	n to show the POA had been			electronic order transmission		
	notified of the adm	inistration of two STAT orders			failures, pharmacy fill review,	and	
		lity was to notify the			unsolicited pharmacy fill(s).		
	responsible party/P				On 11/21/23 the SDC began		
					reeducation to licensed nurse	S	
	2. The record for R	Lesident C was reviewed on			and agency nurses and Quali		
		m. Diagnoses included, but were			Medical Assistant (QMA) on the		
		e pancreatitis with uninfected			process of reordering medical		
		a, and acute pancreatitis with			with emphasis on the use of the		
	infected necrosis.	a, and de die panereum with			EDK and notification to the	10	
	mirected necrosis.				pharmacy to request and		
	a A physician's or	der, dated 9/29/23, indicated to			determine delivery time of		
		antidepressant medication) 20			medications and if back up		
	milligrams once a	-			pharmacy is needed, and		
	Immigrams once a	uay.			notification to provider and		
	The Medication A	dministration Record (MAR)			responsible party if applicable		
		t administered on 10/01/23 and			1		
					Reeducation for new hires wil		
	10/02/23. The documentation in the MAR indicated the medication was not available.				done in orientation and/or dur	ing	
	indicated the medic	cation was not available.			onboarding by the SDC or		
	T1 1				weekend nurse manager.		
		mentation to show the			Onboarding refers to new hire		
	physician had been	notified.			orientation. New hires will reco		
					this education before they sta		
		der, dated 9/29/23, indicated to			their shift. Any new agency sta		
		r Free (a protein supplement) 15			will be educated during orienta		
	grams/100 kilocalo	ories (k-cal) in 30 milliliters twice			by the SDC. Any nurse, QMA	, or	

a day.

agency nurse, will not work until

DEPARTMENT OF HEALTH AND HUN	MAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES
CTATEMENT OF DEFICIENCIES	(V1) DD OVIDED (C

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		JILDING	ONSTRUCTION 00	(X3) DATE COMPL 11/20	ETED	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD		GRANT ST ION, IN 46052		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE
	The MAR indicated	I the medication was not		education is provided. Reeducation was completed	on	
		/01/23 and 10/02/23 between		12/13/202.	OII	
		0 a.m., because the medication		Beginning 12/8/2023, the nur	se	
	was not available.			leaders, DON, ADON, TCN a		
				SDC will pull the eMAR		
		mentation to show the		administration compliance re	port	
	physician had been	notified.		in MatrixCare each day in clir		
		1 1 10/00/00 1 11		whiteboard meeting to review		
		ler, dated 9/29/23, indicated to		medications documented not		
	give promethazine of every 6 hours for na	6.25 milligrams/5 milliliters		administered due to unavaila	•	
	every 6 nours for na	ausea.		The nurse leaders will audit to		
	The MAR indicated	I the medication was not	report to ensure all medications are available per physician orders.			
		1/1/23 at 4:00 a.m., 10:00 a.m.,		If medications are not availab		
		p.m. The medication was not		the medication will be retrieved		
		/2/23 at 4:00 a.m., or 10:00 a.m.		from the Ekit (if applicable) a		
		in the MAR indicated the		the pharmacy and provider w		
	medication was not	available.		notified. Once the medication		
				arrives the medication will be		
		mentation to show the		provided to the resident per		
	physician had been	notified.		physician orders/recommend		
		11/00/00 110 70 7777		This will be an ongoing proce		
		v, on 11/20/23 at 10:58 a.m., LPN		included in the clinical whiteb		
		lication was not available in the en first check the Emergency		meeting. The clinical whitebo checklist will be utilized as ar		
		it was not in the EDK, then call		audit tool.	ı	
		heck the order and request the		audit tool.		
		all the physician, notify them				
		medication and document the				
	information in the r					
				4 How will the facility mor	nitor	
		y, on 11/20/23 at 11:00 a.m., the		its performance to make sure		
		of Nursing indicated if a		solutions are sustained; the p		
		available, to check the EDK.		is implemented, and the corre	ective	
		if it was not in the EDK and		action evaluated for its		
		physician to get a hold order		effectiveness; and the plan of		
	or an alternative me	culcation.		correction is integrated into the	ıe	
	During an interview	v, on 11/20/23 at 3:17 p.m., the		quality assurance system? The Quality Assurance		
	g an mich view	., 11.20.20 at 5.17 p.iii., tile		The Quality / Goulance		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155378	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 11/20	LETED
	PROVIDER OR SUPPLIEF JRE HEALTHCARE		1001 N	ADDRESS, CITY, STATE, ZIP C I GRANT ST ION, IN 46052	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Director of Nursing not available for ad contact the physicia for the medication of medication until it was a current facility processed on 11/20/23 and receive on 11/20/23 at 1:35 must inform the reservation of the resident's physician his or her authority, when there isA not significantlyDocumotification attempt resident electronic in the resident electronic electronic electronic electronic electronic electronic el	indicated if a medication was ministration staff was to an and either get a substitution or get a hold order for the was received. Dicy, titled "Notification of an," dated as last reviewed affrom the Director of Nursing p.m., indicated "The facility ident, consult with the can notify consistent with the resident representative(s) and notify consistent with the resident representative ident, and notify consistent with the resident representative ident, so should be recorded in the		Performance Improver Committee (which constanting of Administrator, DON, A Social Services Director Medical Records, Envisioness Office Manage Medical Director) will nonthly and review resuldits and monitoring the compliance of this correction. Based on the QAPI team, led by the administrator, will resuggestions as needed and the Compliance of this correction. Based on the QAPI team, led by the administrator, will resuggestions as needed and the deficient practice: F 580-Notification of needed and the deficient practice: Residents found to be at the deficient practice: Residents B and C were discharged from facility survey. Phow will the facility survey. How will the facility survey. How will the facility survey. Phow will the facility survey. Transitional Care Nurse pulled the Facility Acity for the past 30 days to new orders and to ensuresidents and/or response.	ment (QAPI) sists of: DON, or, MDS, ronmental e Director, ger and neet sults of the related to plan of nis review additional make d. ce ew orders re action or those affected by re re reprint to ity identify the by the e: ector of and e (TCN) rity Report review all ure	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION N 155378		IDENTIFICATION NUMBER 155378	A. BUILDING B. WING	00	COMPLETED 11/20/2023	
	ROVIDER OR SUPPLIER		1001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST ON, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	•			parties have been notified of the new orders. 3 What measures will be printo place or what systemic changes the facility will make ensure the deficient practice of not recur: On 12/7/2023, the DON provideducation to the ADON, SDC TCN on notifying the resident and/or responsible party on all new orders. On 11/21/2023 the SDC begate reducation to licensed nurses the process of notifying the resident and/or responsible party on all new orders. On 11/21/2023 the SDC begate reducation to licensed nurses the process of notifying the resident and/or responsible party on any new orders. Reeducat for new hires will be done in orientation and/or during Onboarding by the SDC or weekend nurse manager. Onboarding refers to new hire orientation. New hires will receive this education before they start their shift. Reeducation for agast staff will be done by the SDC weekend nurse manager. Any new agency staff will be education by the SDC Reeducation was completed of 12/12/2023. Beginning 12/7/2023, the nurse leaders, DON, ADON, TCN, a SDC will pull the Facility Activic Report (FAR) in MatrixCare early and the start of the solution of the solu	better but to loes ded and l l l l l l l l l l l l l l l l l l l	
				day (M-F) in clinical whiteboar meeting to review all new orde	ers	
				from day prior. The nurse lead	lers	

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will audit the report to ensure all

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	F OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED /2023	
	PROVIDER OR SUPPLIER		10	001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST	•	
SIGNATI	JRE HEALTHCARE	EATPARKWOOD	L	EBAN	ON, IN 46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
					new orders have notifications resident and/or responsible parthis will be an ongoing process included in the clinical whitebout meeting. 4 How will the facility monits performance to make sure solutions are sustained; the plies implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? On 12/8/2023, the Quality Assurance Performance Improvement (QAPI) Committed (which consists of: Administrated DON, ADON, Social Services Director, MDS, Medical Record Environmental Services, Maintenance Director, Busine Office Manager and Medical Director) will meet monthly an review results of the audits and monitoring related to the compliance of this plan of correction. Based on this reviet the QAPI team, led by the administrator, will make additional suggestions as needed. 5 Date of compliance 12/13/2023	arty. ss pard itor that lan ctive e ee tor, rds, ss d d d	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155378	B. WING			11/20/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST				
SIGNATURE HEALTHCARE AT PARKWOOD			LEBANON, IN 46052				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE

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