| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155778 | A. BUILDING 00<br>B. WING | 03/16/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW HEALTHCARE | 1212 E MAIN<br>ATTICA, IN 47918 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00223168, IN00224087, and IN00224706.<br><br>Complaint IN00224087 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00224706 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00223168 - Substantiated. Federal/State deficiencies related to the allegations are cited at F514.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: March 15 and 16, 2017<br><br>Facility number: 000323<br>Provider number: 155778<br>AIM number: 100288440<br><br>Census bed type:<br>SNF/NF: 48<br>Total: 48<br><br>Census payor type:<br>Medicare: 8<br>Medicaid: 30<br>Other: 10<br>Total: 48 | F 0000 | The preparation and/or execution of this plan of correction does not constitute an admission or agreement by this facility of the of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. | |

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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| | These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed on March 20, 2017. | | | |
| F 0514<br>SS=D<br>Bldg. 00 | 483.70(i)(1)(5)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain- | | | |

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| | (i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>Based on interview and record review, the facility failed to maintain clinical records in a complete, readily accessible manner for 3 of 3 clinical records reviewed for physician's orders. (Residents B, C, and D)<br><br>Findings include:<br><br>1. Resident B's clinical record was reviewed on 3/15/17 at 2:00 p.m. The physician's recapitulation of the resident's orders for February, 2017, was not found on the resident's record.<br><br>2. Resident D's clinical record was reviewed on 3/16/17 at 10:35 a.m. The physician's recapitulation of the resident's orders for February, 2017, was not found | F 0514 | The Director of Nursing and Assistant Director of Nursing have received signed orders for all three (3) affected residents and have placed them on the chart. These residents' charts will be audited again for verification. (D)<br><br>An audit will be conducted on all active residents' charts to verify signed physician orders are on the chart. (D)<br><br>The facility has purchased a Medical Record Policy and Procedure Manual from MedRec Systems. We have also contracted with MedRec Systems to come in and train our staff on the proper Medical Record procedures and help us with ways of auditing. MedRec Systems | 04/15/2017 |

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| | on the resident's record.<br><br>3. Resident C's clinical record was reviewed on 3/16/17 at 12:31 p.m. The physician's recapitulation of the resident's orders for February, 2017, was not found on the resident's record.<br><br>The Director of Nursing (DON) was interviewed on 3/16/17 at 2:00 p.m. She indicated the records had been found, the next day, at the physician's offsite office. The recapitulation orders had probably been there for two weeks, for the physician's signatures.<br><br>On 3/16/17 at 1:20 p.m., the DON indicated there was not a policy and procedure for maintaining medical records.<br><br>This Federal tag relates to Complaint IN00223168.<br><br>3.1-50(a)(1)(2) | | consultant has begun this process on March 29, 2017 and is scheduled to return on April 4, 2017.<br><br>An audit will be done monthly for the first 3 months and then quarterly thereafter and discussed at QAA meetings quarterly. (E) | |
| F 0520<br>SS=F<br>Bldg. 00 | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)<br>QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br>(g) Quality assessment and assurance. | | | |

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| | (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. | | | |
| | Based on interview and record review, the facility failed to maintain an effective quality assessment and assurance committee to evaluate activities, identify | F 0520 | The Quality Assessment and Assurance Policy and Procedure has been reviewed and updated per federal and state regulations. (A) | 04/15/2017 |

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| | issues, and develop and implement plans of action to correct identified quality deficiencies. This deficient practice had the potential to affect all 48 residents of the facility.<br><br>Finding includes:<br><br>On 3/16/17 at 1:35 p.m., the Administrator and Director of Nursing (DON) were interviewed. The DON indicated there had not been a Quality Assurance meeting since last August (7 months). The Administrator indicated she could not find any documentation of previous meetings.<br><br>The facility policy titled 'Woodland Manor Policy," dated March 2004, was provided by the Administrator on 3/16/17 at 1:46 p.m. It included but was not limited to, "Purpose: It is the policy of Woodland Manor to establish a systematic, ongoing program for the purpose of evaluating quality improvement progress and for identifying additional improvement opportunities and for the monitoring the care related services. The Quality Assessment and Improvement Committee (QA& [and] I) will be charged with providing a mechanism for Continuous Quality Improvement for facility operations....The facility Quality | | The next QAA meeting is scheduled for 4/7/17 at 2:00 pm. This meeting will include all department managers. During this meeting, all departments will be assessed for quality issues and will be prioritized by the committee members.<br><br>The QAA meeting will be done monthly for the first six (6) months then quarterly thereafter. All QAA meetings for the year will be scheduled in advance for the year and given to QAA committee members. (B)<br><br>A log of the dates and attendees and additional meeting notes as to what quality issues were found and plans of actions will be kept in a QAA binder in the Administrators office. (C)<br><br>Administrator will go over these logs with the owner monthly for the first 6 months and then quarterly, so the owner can audit the above process. (C) | |

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| | Assessment and Improvement Committee includes the facility Administrator, Medical Director, Director of Nursing, Social Services Director or Designee, Activity Director, Food Service Supervisor, Housekeeping and Laundry Supervisor, and the maintenance Supervisor and Grounds Keeper. The Quality Assessment and Improvement Committee shall expand their core members as needed to receive input from internal and external customers and to provide expertise in problem identification, analysis and development of action plans...." The policy did not address frequency of meetings.<br><br>3.1-52(a)(1)(2)(3)<br>3.1-52(b)(1)(2) | | | |