STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155778	A. BUILDING 00 B. WING	10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTHCARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00241800 and IN00241949. Complaint IN00241800 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Complaint IN00241949 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323, F274, and F502. Survey dates: October 5 and 6, 2017 Facility number: 000323 Provider number: 155778 AIM number: 100288440 Census Bed Type: SNF/NF: 40 Total: 40 Census Payor Type: Medicare: 3 Medicaid: 30 Other: 7 Total: 40 These deficiencies reflects State Findings	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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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 13, 2017.			
F 0274 SS=D Bldg. 00	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to complete a comprehensive significant change Minimum Data Set (MDS) assessment for 1 of 7 residents reviewed for MDS assessments (Resident F). Findings include: Resident F's record was reviewed on 10/5/17, at 11:17 a.m. Diagnosis on the admission record included, but not limited to, Parkinson's disease, dementia	F 0274	It is the intent of this facility to complete all significant changes in MDS. 1. The significant change MDS for Resident F has been completed. 2. All residents have the potential to be affected. 3. Residents with significant changes will have MDS completed timely in accordance with RAI manual schedule. 4. Residents with significant change MDS' completed will be brought to the QAPI committee and recommendations made will	10/24/2017

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	with behavioral disturbances, seizures, major depressive disorder, anxiety disorder, and psychological and behavioral factors. A quarterly MDS assessment, dated 5/25/17, indicated Resident F had Brief Interview for Mental Status (BIMS) score of 11 (indicated moderate cognitive impairment), disorganized thinking, and verbal behaviors directed towards others. She required extensive assistance of 2 staff for bed mobility, transfers, and dressing. Extensive assistance of 1 staff for walking in her room and corridor, toilet use and personal hygiene. Resident F was totally dependent with 1 staff for bathing. She was frequently incontinent of urine but always continent of bowel. No indication of falls, 64 inches tall, no indication of weight loss or weight gain, and no pressure ulcers. A quarterly MDS assessment, dated 8/23/17, indicated Resident F had a BIMS score of 8 (a loss of 3 points from the previous assessment indicative of a notable change in mental status). She required extensive assistance of 2 staff for bed mobility, transfers, walking in the room, locomotion on and off the unit, dressing, toileting, and personal hygiene. Supervision with set up for walking in the corridor and supervision with		be followed. MDS coordinator has been re-educated. F_274	

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	assistance of 1 staff for eating. Resident F was total dependence of 2 staff for bathing. She was frequently incontinent of bladder and bowel. 2 falls without injury and 2 falls with injury since the prior assessment, 64 inches tall, significant weight gain, and 1 stage II pressure ulcer. A nurse's note, dated 9/6/17, indicated, "8/23 MDS completed. Resident has had a significant change in status r/t (related to) significant weight gain, new right leg 2 pressure ulcer, new order to d/c (discontinue) antipsychotic and change in ADL's (activities of daily living) status. Will schedule significant change MDS." A review of MDS assessments from 5/25/17 to 10/5/17 did not indicate any significant change assessments. The "Weights and Vitals Summary" indicated weights and warnings: a. 4/5/17, 302.8 pounds b. 5/30/17, 311.2 pounds c. June 2017, no weight indicated d. 7/5/17, 314.2 pounds e. 8/1/17, 348.6 pounds f. 8/9/17, 347.6 pounds g. 8/16/17, 349.2 pounds h. 8/23/17, 351.4 pounds i. 9/11/17, 341.0 pounds, +10% change (comparison weight 4/5/17, 302.8			

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	pounds, +38.2 pounds) j. 9/26/17, 330.6 pounds, -5% change (comparison weight 8/31/17, 351.4 pounds, -20.8 pounds) k. 10/3/17, 346.6 pounds, stuck out by contracted MDS nurse, indicated, incorrect documentation l. 10/5/17, 328.4 pounds, -5% change (comparison weight 9/6/17, 346.4 pounds, -18 pounds) A dietary progress note, dated 8/16/17, indicated, "Significant weight increase: current weight rechecked when measured at 348.6 pounds. An increase of 10% in one month ...Current BMI is now over 55. Off the chart." During an interview, on 10/6/17 at 10:37 a.m., Interim DON (Director of Nursing) indicated, "the contracted MDS nurse was not here today. When spoken to by telephone indicated, a significant change MDS still needed to be completed, it was late being completed." A copy of Chapter 2: Assessments for the RAI (Resident Assessment Instrument) of the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual indicated, " ...03. Significant Change In Status Assessment (SCSA): The SCSA is a comprehensive assessment for a resident that must be completed when the			

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	IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either improvement or decline ...A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan ...Decline in two or more of the following ...Any decline in ADL physical functioning area where resident is newly coded as extensive assistance ...emergence of unplanned weight loss (5% change in 30 days or 10% change in 180 days) ...." 3.1-31(d)(1)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview and record review, the facility failed to ensure elopement assessments were completed (Resident C), and to ensure a non-pressure form and incident report were completed post-fall (Resident G), for 2 of 6 residents reviewed for accidents. Findings include: 1. Resident C's record was reviewed on 10/5/17 at 11:08 a.m. A admission elopement risk assessment, dated 4/24/17, indicated the resident was determined to be at risk for elopement.	F 0323	It is the intent of this facility to complete all elopement assessments, non pressure forms and incident reports post fall. 1. Resident C still resides a the facility and no further elopements have occurred. Resident G still resides at the facility . 2. All residents have the potential to be affected. 3. a. Assessments for those residents with a history of elopements have been updated and quarterly assessment will continue to be completed quarterly or with and elopement incident. Any newly admitted	10/24/2017

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	An annual MDS (Minimum Data Set) assessment, dated 5/1/17, indicated the resident had severe cognitive deficit, diagnoses which included, but were not limited to, dementia, and exhibited wandering behaviors. A care plan, dated 5/8/17, indicated the resident was at risk fro elopement related to impaired safety awareness due to dementia. Interventions included, but were not limited to, observe whereabouts regularly, redirection, provide diversional activities, and wanderguard (a signaling device bracelet) placement. Review of a reportable incident document, dated 7/30/17, indicated the resident had exited the building by the side emergency exit door. No evidence of the completion of an elopement assessment was observed. A nurse's note, dated 7/30/17 at 5:45 p.m., indicated the resident had been seen outside the facility by another resident. Staff assisted the resident back inside the building. The resident indicated she wanted to go home. The resident had followed a visitor out of the door. Physical assessment indicated no injury or complaints. Review of a reportable incident		resident with a history of elopements will be placed in the elopement binder, assessment completed and reviewed quarterly. Care plans were audited to ensure each care plan contains an elopement intervention. b. All falls are documented at the time of a fall and documentation notes include the notification of the MD and family . A head to toe assessment is completed and all skin alterations are documented in the clinical record. Weekly skin checks are completed with any skin injury. In addition, fall care plans are updated immediately and are reviewed with IDT during the weekly care plan meetings. 4. Falls and elopement will be brought to the monthly QAPI meeting and reviewed . Recommendations made by the QAPI committee will be followed. F-323 All Licensed nursing staff have been in-serviced	

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	document, dated 9/26/17, indicated the resident was observed outside of the facility . The resident had exited the building by the side emergency exit door which had not latched properly. No evidence of the completion of an elopement assessment was observed. No evidence of a corresponding nurse's note related to the resident exiting the facility was observed. During an interview, on 10/5/17 at 12:00 p.m., the interim DON (Director of Nursing) indicated elopement assessments would be completed at admission, quarterly, and as needed. During an interview, on 10/6/17 at 9:50 a.m., the Administrator indicated the current policy of the facility was an elopement policy would be completed at admission, quarterly, and as needed. The only elopement assessment for Resident C was completed on 4/24/17. No other elopement assessments had been completed on the resident. 2. Resident G's record was reviewed on 10/5/17 at 10:29 a.m. The care plans indicated the resident was at risk for falls related to impaired safety awareness. A review of progress notes, dated 9/27/17, included but was not limited to, resident had fall in room that resulted in			

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	injury. A skin tear to right hand, and bleeding gums noted. A review of progress notes, dated 9/28/17 at 1:06 a.m., included but was not limited to, fall follow up continued and discoloration noted to chin. A review of progress notes, dated 9/28/17 at 10:05 a.m., included but was not limited to, fall follow up continued and slight bruising noted around mouth from fall. A review of progress notes, dated 9/29/17 at 3:47 a.m., included but was not limited to, fall follow up continued with discolorations noted to face. A review of progress notes, dated 9/30/17 at 7:40 a.m., included but was not limited to, fall follow up continued and discolorations to mouth and left side of face continue to fade. During a review of the resident's skin observation assessments, the assessments lacked documentation of a completed non-pressure form for the resident's bruised area to face. During a review of the residents risk management incident/accident assessments, the assessments lacked			

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	documentation of a completed report of incident/accident assessment when the bruise was discovered. During an interview on 10/5/17 at 3:13 p.m., the Interim DON (Director of Nursing) indicated the resident did not have documentation for measurements related to the bruise discovered post fall and indicated she would have some one obtain the measurements. During an observation and interview on 10/5/17 at 3:18 p.m., the MDS (Minimum Data Set) Consultant indicated the bruise to the resident's left side of face measured at 7.6 cm (centimeters) x 6 cm, and was bluish-purple in color. During an interview on 10/6/17 at 9:39 a.m., the Interim DON indicated when a bruise was discovered post fall an incident report should be completed with measurements. On 10/6/17 at 9:39 a.m., the Interim DON provided a document titled, "Fall and Fall Risk, Managing," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Monitoring subsequent falls and fall risk... 5. Nursing staff will observe for delayed complications of a fall for			

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	approximately forty-eight hours after an observed or suspected fall, and will document findings in the medical record. 6. Documentation will include an observed signs or symptoms of pain, swelling, bruising...." On 10/6/17 at 9:39 a.m., the Interim DON provided a document titled, "Skin Tears, Abrasions and Minor Breaks, Care of," and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: the purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears and minor breaks in the skin. Preparation:... 4. Generate non-pressure form and complete...Documentation:... 2. generate non-pressure form... 9. when an abrasion/skin tear/bruise is discovered, complete a report of incident/accident. 3.1-45 (a)(1) 3.1-45(a)(2)			
F 0502 SS=D Bldg. 00	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review,	F 0502	It is the intent of this facility to	10/24/2017

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	the facility failed to ensure lab draws were performed as ordered and performed timely for 1 of 3 residents reviewed for labs (Resident #F). Findings include: Resident F's clinical record was reviewed on 10/5/17 at 11:17 a.m. Diagnosis on the admission record included, but not limited to, Parkinson's disease, dementia with behavioral disturbances, seizures, major depressive disorder, anxiety disorder, and psychological and behavioral factors. The August 2017 Physician's Orders, indicated an order on 6/29/17 for a CMP (comprehensive metabolic panel to evaluate organ function and check for conditions such as diabetes, liver disease and kidney disease) and Lipid Panel (blood test that measures fats and fatty substances to include cholesterol, triglycerides) every night shift every 3 months starting the 14th for 1 day in September, start date 9/5/17. No lab results for were located in the clinical record for September 2017. During an interview with the interim DON, on 10/5/17 at 3:30 p.m., indicated she had observed the order for a CMP and Lipid panel ordered for 9/5/17. After		complete all labs. F502 1. Resident F still resides at the facility and the lab order has been followed, lab drawn and MD notified of results . No additional orders resulted 2. All residents have the potential to be affected. 3. Orders for labs are entered into the EMR, a lab requisition completed and identified for a draw when the lab technician arrives to the facility . The DON/ designee is to follow up with lab orders to ensure completion. Lab results are faxed/ called to the MD; orders, if applicable, entered into EMR and followed. 4. Any deviation from the Lab Policy will be brought to the QAPI monthly meeting and recommendations made by the Committee will be followed. All Licensed Nursing Staff have in-serviced.	

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	a call to the lab it was determined the labs were not drawn as ordered. During an interview with the interim DON, on 10/6/17 at 10:37 a.m., indicated, there was a system for labs. The night nurse filled out requisitions for lab draws During an interview with RN #7, on 10/6/17 at 10:40 a.m., indicated, when a lab order was obtained it was to be entered into the EMR (electronic medical record), a lab requisition filled out, and when the lab technician came on Tuesday mornings they were given a list of labs and the requisition forms. The ADON (assistant director of nursing) was responsible to assure follow-up was completed. I cannot tell you why Resident F's lab was not done. On 10/6/17 at 11:20 a.m., the interim DON provided a policy, titled, "Parkview Healthcare Lab Policy", undated. The policy indicated, "Policy: It is the policy of the facility that labs will be drawn per MD order. Protocol: The receiving nurse will ensure that ordered labs: 1. Nurse will complete the lab requisition and will place in lab folder 2. Order placed into Point Click are under "orders" 3. The nurse on night shift will accompany the lab tech to the resident room for the lab			

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	draw 4. The results are faxed to the nurses station 5. MD notified of results via fax-or if critical lab results-the MD will be called 6. The MD contact date/time is written onto the lab result 7. The nurse on the next shift, following the lab draw/result, ensures that MD was contacted by fax or phone 8. ADON/designee reviews all labs draws since last review to ensure that the documentation has been completed; that the MD has been notified; that any abnormalities have addressed by MD; any resulting new orders are written in PCC (a new lab draw order is carried out as above) and communicated/documented to the family." 3.1-49(a)			