STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. BUILDING 00 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW CARE CENTER	2819 NORTH ST JOSEPH AVE EVANSVILLE, IN 47720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Complaint IN00403004. Complaint IN00403004 - Federal/state deficiencies related to the allegations are cited at F583, F849. Survey dates: March 13, 14, 2023. Facility number: 000239 Provider number: 155348 AIM number: 100290150 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 30 Medicaid: 26 Other: 4 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 17, 2023.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Parkview Care Center agrees with the allegations and citations listed. Parkview Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christina Wilson	Executive Director	03/27/2023

Any defiencystatement 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 disclo 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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	care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure dignity and privacy was provided for 1 of 1 residents observed for care. A privacy curtain was not pulled while a resident received a bed bath. (Resident B) Finding includes: On 3/14/23 at 10:33 a.m., CNA 1 was observed to give Resident B a bed bath. CNA 1 entered the	F 0583	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B did not experience a negative outcome from the privacy curtain not being pulled taunt and leaving a small space between curtain and wall during a bed bath. The resident room door was closed. Curtains and blinds were	03/29/2023

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	room, donned gloves, shut the door, entered the bathroom, turned on the faucet and wet washcloths. CNA 1 walked to the bed, raised the bed with the bed control, obtained clothing out of the closet, took Resident B's gown off and proceeded to give Resident B a bed bath. CNA 1 did not pull the privacy curtain between Resident B and her roommate, who was awake and lying in bed watching TV. During the bed bath, CNA 1 was observed to have conversation with Resident B's roommate. On 3/14/23 at 11:04 a.m., CNA 1 indicated that for privacy during a resident's bed bath, she knocks on the door, tells the resident what she is going to be doing, closes the window curtains and blinds, when you do the top, cover the resident, when doing the bottom, cover the resident. On 3/14/23 at 12:56 a.m., the ADON (Assisted Director of Nursing), provided the policy on dignity with a reviewed date of 5/19/20. The policy included, but was not limited to: Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the residents' goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input. This Federal tag relates to Complaint IN00403004. 3.1-3(a) 3.1-3(p)(4)		also closed. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents receiving care who have a roommate have the potential to be affected. DON/designee to provide education on providing privacy while care is being provided by ensuring the privacy curtain is completely pulled. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee to provide education on providing privacy while care is being provided by ensuring the privacy curtain is completely pulled closed in semi-private rooms to maintain privacy. DON/designee to complete random observations to ensure privacy is maintained during care services by completing pulling the privacy curtain closed in semi-private rooms. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee to complete random observations to ensure	

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			privacy is maintained during care services by completing pulling the privacy curtain closed in semi-private rooms. Observations to occur: 4 random residents daily x's 4 weeks, 4 random residents weekly x's 4 weeks, 4 random residents monthly x's 4 weeks for a total of 6 months of monitoring. Any findings will be addressed. Compliance date: March 29, 2023. The Administrator at Parkview Care Center is responsible in ensuring compliance in this Plan of Correction	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as			

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	specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the			

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	appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged			

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	violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from			

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	the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on interview and record review, the facility failed to ensure communication in a resident's change in condition was provided to a hospice provider. Hospice was not notified when a resident was sent to the hospital. (Resident B)	F 0849	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B did not experience a negative outcome from not being	03/29/2023

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	Finding includes: On 3/13/23 at 11:02 a.m., Resident B's clinical record was reviewed. Resident B had diagnoses that included, but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, osteoarthritis, fracture of unspecified part of unspecified clavicle. A quarterly MDS (Minimum Data Set), dated 1/19/23, indicated Resident B's cognition was severely impaired. A care plan initiated on 10/14/22 included, but was not limited to, (name of resident) is receiving hospice services through (name of hospice) for diagnoses of stroke. Interventions included, but were not limited to, work cooperatively with the hospice team to provide resident's spiritual, emotional, intellectual, physical, and social needs. Date initiated 10/22/22. A progress note dated 1/16/23 at 10:44 a.m., included, " Note text: Notified (name of daughter) (daughter) that resident is going to be sent to the ER for right shoulder pain. (Name of daughter) verbalized understanding and gave the OK." No communication was documented in the progress notes that hospice was notified of Resident B being sent to the hospital. A change in condition evaluation form dated 1/16/23 was reviewed and indicated Resident B's daughter and primary care clinician were notified of the change in condition, to send to the ER for evaluation and treatment per the primary clinician. A transfer form dated 1/16/23 was reviewed and indicated Resident B's daughter was notified of the transfer to the hospital		notified of the change in condition. Facility notified the physician and responsible party of the change in condition on January 16, 2023, by the DON/designee. DON/designee notified hospice provider of the change in condition and ER transfer while they were in the facility during the change in condition and as resident was being transferred to the ER on January 16, 2023. Again notified hospice provider on March 15, 2023. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents receiving hospice services have the potential to be affected by alleged deficient practice. DON/designee will identify any resident receiving hospice services that have had a change in condition x's previous 30 days to ensure notifications to hospice was made. Any findings will be addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to licensed nursing staff on hospice notifications when a change of condition is identified. DON/designee will audit the	

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	On 3/13/23 at 8:47 a.m., Hospice staff 1 indicated hospice was not notified that Resident B was sent to the ER (Emergency Room) on 1/16/23, it was found out when a hospice staff member went to the facility the next day. On 3/14/23 at 11:00 a.m., an untimed hospice communication form was reviewed dated 1/16/23 that included " Bruising found on R cheek & Shoulder (clavicle). (name of resident) complains of pain on movement. Full bed bath, Skin care, Hair care provided Linen change. Pepsi opened. RX given and she has calmed." A hospice communication form dated 1/17/23 was reviewed and included: Type of Visit: Nursing. Facility staff Member Name(s): (name) -Nurse, (name) aide, (name) DON. Comments: " Routine visit/Fall/ER/visit/follow-up. Hospice NOT notified pt was sent to (name of hospital) ER last night after Hospice HHA reported New bruising to L clavicle. L/R pelvis Xray obtained to verify clavicle fx pelvic fx. pt pain under control, family member (name) notified, MSW spoke with her." On 3/14/23 at 11:50 a.m., LPN 1 indicated the facility does not send a hospice resident to the ER unless hospice is called first, hospice normally calls the family, its a team effort, orders are obtained from hospice to send to the ER. On 3/14/23 at 12:04 p.m., the ADON indicated she did not find documentation that hospice was notified of Resident B being sent to the hospital. On 3/14/23 at 12:14 p.m., the ADON indicated she had spoken to the DON , who was not at the facility, the DON indicated hospice was in the building when Resident B was sent to the hospital. No documentation was provided.		medical record daily to ensure notifications have been made to hospice providers when there is a change in condition. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will audit the medical record daily to ensure notifications have been made to hospice providers when there is a change in condition. Auditing to occur: 4 hospice residents experiencing a change in condition (if a change exists) daily x's 4 weeks, 4 residents hospice residents experiencing a change in condition (if a change exists) weekly x's 4 weeks, 4 hospice residents experiencing a change in condition (if a change exists) x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. Compliance date: March 29, 2023. The Administrator at Parkview Care Center is responsible in ensuring compliance in this Plan of Correction	

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	On 3/14/23 at 12:59 p.m., the ADON provided a document titled "Hospice Coordination of Care" with a revision date of 8/18/2022. The document included, but was not limited to, (D) a communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, pr emotional status, (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change level services provided. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of resident property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. Each LTC facility arranging for the provision of hospice care under written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. ...(iii) Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by			

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	other physicians. This Federal tag relates to Complaint IN00403004. 3.1-37(a)			