STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155746	A. BUILDING 00 B. WING	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00404821. This visit included a State Residential Licensure Survey. Complaint IN00404821 - No deficiencies related to the allegations are cited. Survey dates: April 3, 4, 5, 6, 10, and 11, 2023. Facility number: 000539 Provider number: 155746 AIM number: 100267280 Census Bed Type: SNF/NF: 35 SNF: 1 Residential: 16 Total: 52 Census Payor Type: Medicare: 10 Medicaid: 10 Other: 16 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/13/23.	F 0000	**The preparation and execution of the Plan of Correction does not constitute admission or agreement, by the provider of the alleged deficiencies.** **We are requesting a desk review do too the low scope and severity.**	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:			

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

Max W. Jones | Administrator | 05/10/2023

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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	§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to an uncovered urinary catheter bag for 1 of 1 residents reviewed for urinary catheters. (Resident 31) Finding includes: On 4/3/23 at 9:21 a.m., and 4/4/23 at 1:49 p.m., Resident 31 was observed in bed. There was an uncovered urinary catheter bag hanging on the side of the bed with urine visible in it. The resident's record was reviewed on 4/4/23 at 2:33 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder and prostate cancer. A Physician's Order, dated 2/8/23, indicated to insert an indwelling catheter. A Catheter Care Plan, dated 2/15/23, included the intervention to keep the catheter drainage bag covered to maintain the resident's dignity and privacy. Interview with the Director of Nursing, on 4/4/23 at 2:51 p.m., indicated the catheter bag should have been covered. 3.1(9)(a)	F 0557	**F 557 (Respect, Dignity/Rights to have Personal Property)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 13 Urinary catheter bag was immediately cover with a privacy bag. R13 continued to have his urinary catheter bag cover while in bed or up in w/c. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents with Urinary Foley Catheters have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** The nursing staff will be re-educated on maintaining residents dignity related to covering urinary catheter bags.	04/28/2023

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place; Observational rounds will be conducted 5x per week, x4 weeks and weekly thereafter to ensure that urinary catheter bags covers are in place for compliance. A QA tool will be used to monitor compliance. All QA monitoring tools will be discussed and reviewed in QAPI monthly or until compliance is met. **Completion Date: 4-28-2023** **F 557 (Respect, Dignity/Rights to have Personal Property)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 13 Urinary catheter bag was immediately cover with a privacy bag. R13 continued to have his urinary catheter bag cover while in bed or up in w/c.	

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			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents with Urinary Foley Catheters have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** The nursing staff will be re-educated on maintaining residents dignity related to covering urinary catheter bags. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** Observational rounds will be conducted 5x per week, x4 weeks and weekly thereafter to ensure that urinary catheter bags covers are in place for compliance. A QA tool will be used to monitor compliance. All QA monitoring tools will be discussed and reviewed in QAPI monthly or until compliance is met.	

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			Completion Date: 4-28-2023 **F 557 (Respect, Dignity/Rights to have Personal Property)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 13 Urinary catheter bag was immediately cover with a privacy bag. R13 continued to have his urinary catheter bag cover while in bed or up in w/c. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents with Urinary Foley Catheters have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** The nursing staff will be re-educated on maintaining	

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			residents dignity related to covering urinary catheter bags. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** Observational rounds will be conducted 5x per week, x4 weeks and weekly thereafter to ensure that urinary catheter bags covers are in place for compliance. A QA tool will be used to monitor compliance. All QA monitoring tools will be discussed and reviewed in QAPI monthly or until compliance is met. **Completion Date: 4-28-2023** **F 557 (Respect, Dignity/Rights to have Personal Property)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 13 Urinary catheter bag was immediately cover with a privacy bag. R13 continued to have his	

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			urinary catheter bag cover while in bed or up in w/c. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents with Urinary Foley Catheters have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** The nursing staff will be re-educated on maintaining residents dignity related to covering urinary catheter bags. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** Observational rounds will be conducted 5x per week, x4 weeks and weekly thereafter to ensure that urinary catheter bags covers are in place for compliance. A QA tool will be used to monitor compliance. All QA monitoring tools will be discussed and reviewed in QAPI monthly or until	

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			compliance is met. **Completion Date: 4-28-2023** **F 557 (Respect, Dignity/Rights to have Personal Property)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 13 Urinary catheter bag was immediately cover with a privacy bag. R13 continued to have his urinary catheter bag cover while in bed or up in w/c. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents with Urinary Foley Catheters have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;**	

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			The nursing staff will be re-educated on maintaining residents dignity related to covering urinary catheter bags. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** Observational rounds will be conducted 5x per week, x4 weeks and weekly thereafter to ensure that urinary catheter bags covers are in place for compliance. A QA tool will be used to monitor compliance. All QA monitoring tools will be discussed and reviewed in QAPI monthly or until compliance is met. **Completion Date: 4-28-2023**	
F 0574 SS=C Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each			

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	resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system			

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	(as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.			
	Based on interview and record review, the facility failed to ensure the residents were informed of their right to formally complain to the Indiana Department of Health (IDOH) and were given information on how to contact IDOH. This had the potential to affect the 36 residents who resided in the facility. Finding includes: During the Resident Council group meeting on 4/5/23 at 9:50 a.m., 6 of the 6 residents in attendance, including the Resident Council President, indicated they did not know how to contact IDOH to make a formal complaint. They were not aware of where they could find the contact information for IDOH and could not	F 0574	**F 574 Required Notices and Contact Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The information board containing the Required Notices and Contact information was immediately relocated to ensure accessibility for all residents. New signage was posted with the correct font per state guidelines.	04/28/2023

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	remember the information being discussed at previous Resident Council meetings. The Resident Council meeting minutes for the last 3 months indicated there was not a discussion regarding the right of residents to formally complain or how to contact IDOH. The hotline number to contact IDOH was located on a bulletin board by the nurses station. The posting was on the bottom right corner of the board but was not in view because a medication cart was in front of the posting. The medication cart was usually parked in front of the board throughout the day. Interview with the Activity Director on 4/5/23 at 10:10 a.m., indicated she was unaware the residents did not know how to make a complaint to IDOH or that the information was not easily accessible to the residents. 3.1-8(b)(4)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Residents and staff were educated on the location and the notices and contact information required in this posting. All new admissions and new team members to the community will be informed upon admission and new team member orientation of the location of the notices and contact information per state guidelines. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place;** The administrator/designee will conduct monthly rounds to ensure the information board/postings are in place to ensure compliance. These monthly QA rounds will be review monthly in QAPI x3 or until	

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			compliance is met. **Completion Date: 4-28-2023**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a dependent resident related to not assisting a resident with removal of facial hair and completing nail care for 1 of 1 residents reviewed for activities of daily living (ADLs). (Resident 15) Finding includes: On 4/4/23 at 9:50 a.m., Resident 15 was observed sitting in a wheelchair in her room. The resident had facial hair to the chin and upper lip. The resident's nails had dark debris underneath them. On 4/5/23 at 11:11 a.m., Resident 15 was observed sitting in a lounge area visiting with her daughter. The resident still had facial hair and dirty fingernails. Interview at that time with the daughter indicated she was unsure when the last time the resident had been shaved. She had asked in the past for the staff to leave a wash cloth in her room so she could clean the resident's fingernails but they never had left one in the room.	F 0677	**F 677 (ADL Care Provided for Dependent Residents)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R15 was immediately shaved and nail care was rendered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient**	04/28/2023

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	On 4/6/23 at 10:14 a.m., Resident 15 was observed sitting in a wheelchair in her room. The resident still had facial hair and dirty fingernails. LPN 1 was administering the resident her medications then started to leave the room. Interview with the LPN at that time indicated she knew the resident would refuse shaving and nail care at times and the CNAs should have been documenting when the resident refused. Record review for Resident 15 was completed on 4/4/23 at 2:37 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety and arthritis. The Annual Minimum Data Set (MDS) assessment, dated 1/14/23, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist for personal hygiene. A Care Plan, dated 12/9/21 and revised on 3/7/23, indicated the resident required assistance with ADLs due to weakness, possibly vision impaired, dementia, impaired mobility and balance. An intervention included to assist with shaving and nail cleaning as needed. There was no documentation to indicate the resident had recently refused shaving or nail care. Interview with the Director of Nursing on 4/6/23 at 1:58 p.m., indicated the resident would refuse care at times. The staff should have been documenting when she refused care but had not. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)		**practice does not recur;** The nursing staff will be educated/in-serviced on the importance of providing the necessary care for dependent residents who require facial hair removal and nail care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** The DON/Designee will conduct observational rounds 5x weekly for x4 weeks and weekly thereafter to ensure compliance. All noncompliant issues will be discussed and reviewed in QAPI monthly x3. The QA Committee will review the data to ensure that the threshold for compliance of 95% is met. If threshold is not met an action plan will be developed. The QA audits will be on-going. **Completion Date: 4-28-2023**	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 2 of 4 residents reviewed for non-pressure related skin conditions. (Residents 136 and 15) Findings include: 1. On 4/3/23 at 12:38 p.m., Resident 136 was observed lying in bed. The resident had a dark red/purple discoloration to the inside of his left hand. On 4/5/23 at 11:08 a.m., Resident 136 was observed sitting in a wheelchair in his room. The same discoloration was observed. On 4/6/23 at 10:48 a.m., Resident 136 was observed sitting in a wheelchair in the therapy room. The same discoloration was observed. Record review for Resident 136 was completed on 4/5/23 at 3:51 p.m. Diagnoses included, but were not limited to, anemia, hypertension, diabetes mellitus, and peripheral vascular disease.	F 0684	**F 684 (Quality of Care)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R136 A hand assessment was conducted. R136 denied pain or discomfort. Doctor was notified and received a new order. R15 A finger assessment was conducted. R15 denied pain or discomfort. Doctor was notified and received a new order. **How other residents having the potential to be affected by the same deficient practice and will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice.	04/28/2023

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	The Admission Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 2+ person assist with bed mobility, transfers, and personal hygiene. The resident required an extensive 1 person assist with dressing and toilet use. A Care Plan, dated 3/25/23 and revised on 4/5/23, indicated the resident was prescribed an anticoagulant/antiplatelet therapy. An intervention included to observe for signs of active bleeding which included ecchymotic (bruised) areas. A Care Plan, dated 3/24/23 and revised 4/5/23, indicated the resident had delicate skin and was a high risk for bruises and skin tears. An intervention included to observe for bruises with routine care and showers and to report bruises to the nurse. The April 2023 Physician's Order Summary indicated an order for pentoxifylline (increases blood flow in arteries) 400 mg (milligrams) three times a day. There was no documentation to indicate the resident's discoloration had been assessed or was being monitored. Interview with the Director of Nursing (DON) on 4/6/23 at 1:58 p.m., indicated they were unaware of the resident's discoloration and would assess the area. 2. On 4/4/23 at 9:50 a.m., Resident 15 was observed sitting in a wheelchair in her room. The resident had a purple discoloration observed to her left middle finger.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The nursing staff was educated/in-serviced of monitoring and assessment of skin discoloration as well as providing treatment in accordance Doctor's order. A skin sweep was conducted for all residents to ensure compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** The DON/Designee will audit the skin assessments 5x per week for x4 weeks and weekly thereafter to ensure compliance. These tools will be reviewed monthly in QAPI x 3. The QA Committee will review that data to ensure the threshold for compliance of 95% is met. If threshold is not met an action plan will be developed. The QA audits will be on-going. - - - - - - -	

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	On 4/5/23 at 11:11 a.m., Resident 15 was observed sitting in a lounge area visiting with her daughter. The resident still had a purple discoloration observed to her left middle finger. Interview at that time with the daughter indicated she did not know about the discoloration. She was aware of discolorations in the past from laboratory draws but was unsure how the resident could have received the discoloration on her finger. On 4/6/23 at 10:14 a.m., Resident 15 was observed sitting in a wheelchair in her room. The resident's discoloration to the finger still remained. LPN 1 was administering the resident her medications then started to leave the room. Interview with the LPN at that time indicated she was unsure how the resident received the discoloration to her finger. The discoloration should have been assessed and monitored. Record review for Resident 15 was completed on 4/4/23 at 2:37 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety and arthritis. The Annual Minimum Data Set (MDS) assessment, dated 1/14/23, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Care Plan, dated 2/15/22 and revised 1/26/23, indicated the resident had delicate skin and a high risk for bruises and skin tears. An intervention included to observe for bruises with routine care and showers and to report bruises to the nurse. There was no documentation to indicate the		**Completion Date** **4-28-23**	

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	resident's discoloration had been assessed or was being monitored. Interview with the Director of Nursing on 4/6/23 at 1:58 p.m. indicated she could not find any documentation the resident's discoloration had been assessed and was being monitored. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident received proper treatment and care related to oxygen administration flow rate for 1 of 1 residents reviewed for respiratory care. (Resident 2) Finding includes: On 4/6/23 at 11:50 a.m., Resident 2 was observed seated in a recliner in his room. He was wearing a nasal cannula and oxygen was flowing at 3 liters per minute (lpm) from the oxygen concentrator. On 4/6/23 at 1:43 p.m., the resident was observed again in his room with the Director of Nursing (DON), the oxygen was flowing at slightly above	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R2 oxygen was immediately changed and administered per the physicians order. R2 was assessed and had no negative outcomes. **How other residents having the**	04/28/2023

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	2.5 lpm. The resident's record was reviewed on 4/5/23 at 1:41 p.m. Diagnoses included but were not limited to, asthma and arteriosclerotic heart disease. A Physician's Order, dated 3/1/22, indicated oxygen at 2 lpm continuously to maintain oxygen saturation above 90%. Interview with the DON on 4/6/23 at 1:43 p.m., indicated the oxygen was not on the correct setting. 3.1-47(a)(6)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents who have orders for O2 have the potential to be affected this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not occur;** The licensed staff will be re-inserviced on proper treatment and care related to oxygen administration flow rates according to Doctors orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** The DON/Designee will conduct observational rounds 5x per week x4 weeks and weekly thereafter to ensure compliance. All noncompliant issues will be discussed and reviewed in QAPI monthlyx3. The QA Committee will review the data to ensure for compliance of 95% is met. If threshold is not met an action plan will be developed. The QA audits will be on-going.	

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:		**Completion Date: 4-28-2023**	

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to inaccurate documentation of employee COVID-19 test results, (Employee 1 and 2), lack of a policy related to care for COVID-19 positive residents, and hand hygiene during medication pass for 2 staff members observed during medication pass. (QMA 1 and LPN 2) Findings include: 1. The employee COVID-19 testing results and logs were reviewed on 4/6/23. Employee 1 was tested on 2/6/23, the result was positive. Contact tracing was conducted and 8 residents that the employee had been in contact with were tested for COVID-19. There were no positive residents. Employee 2 was tested on 2/9/23, the result was positive. All residents in the facility were tested, no positive residents were identified. The February 2023 COVID-19 tracking log indicated Employee 1 had returned to work on 2/8/23 and was noted as negative for COVID-19. Employee 2 returned to work on 2/11/23 and was noted as negative for COVID-19. Interview with the Infection Control Nurse, on 4/6/23 at 10:10 a.m., indicated she was unsure why the employees had positive test results, but returned to work after 2 days, and were noted as negative on the tracking log. She later indicated the test results had been filled out incorrectly, the employees had not been positive for COVID-19 at that time.	F 0880	**F880 Infection Prevention & Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** E1 & E2 documentation was corrected to indicate that E1 and E2 had negative results. QMA 1 was educated on proper handwashing technique when obtaining blood sugars. LPN 2 was educated on proper hand washing technique during insulin administration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not occur;** Parkview Haven has put in place and implemented infection control guidelines that includes prevention measures and/or the containment	04/28/2023

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	2. The policy related to care and assessment for COVID-19 positive residents was requested for review on 4/11/23. No policy was provided. Interview with the Infection Control Nurse, on 4/6/23 at 10:10 a.m., indicated COVID-19 positive residents were to have a full assessment and vitals taken every shift while in isolation. Interview with the Director of Nursing, on 4/11/23 at 2:00 p.m., indicated they did not have a policy, they were following Center for Disease Control (CDC) guidelines. She was not aware the CDC guidance no longer included resident assessment guidelines, and facilities were to include that in their own policy. 3. On 4/4/23 at 10:02 a.m., QMA 1 was observed preparing to complete a blood glucose test on a resident. While at the medication cart, the QMA donned a pair of latex gloves. She then closed the computer, locked the medication cart, gathered the glucose testing supplies and walked down the hall to the resident's room. She knocked on the door and moved a wheelchair while wearing the gloves. She tested the resident's glucose level via finger stick, gathered the testing supplies, and exited the room. She walked down the hall to the medication cart and then removed her gloves. Interview with the QMA at that time, indicated she was not aware she should not have worn gloves during the entire process and while touching other things. 4. On 4/5/23 at 4:05 p.m., LPN 2 was observed preparing to give a resident an insulin injection. She had not performed hand hygiene prior to inserting the syringe into the insulin vial and		of COVID 19 related to documentation. The Infection Preventionist will implement and maintain accurate documentation when an employee or resident test positive for Covid19. Covid19 policies were put in place to indicate care of a resident when test positive. Staff were educated on ensuring infection control guidelines including Covid19 policies (to assist in preventing and/or containing Covid19) were in place and implemented. They were also educated on having policies in place for care of residents who have tested positive for COVID 19. The Infection Control nurse was educated on the accuracy of documentation as it relates to employees/residents who test positive for Covid19. The licensed staff will be educated on infection control guidelines as it relates to the care of positive residents and proper hand washing during medication pass. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** DON/designee will review infection control Covid 19 policies and measure taken for positive residents/staff including	

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	drawing up the insulin. She then entered the resident's room, donned a pair of gloves and gave the injection. She removed the gloves and disposed of them, took the resident to the dining room, then returned to the medication cart. She had not performed hand hygiene. Interview with the LPN at that time, indicated she should have washed her hands. The policy, "Handwashing/ Hand Hygiene", was received from the DON on 4/6/23, indicated, "...Use an alcohol based hand rub...or soap and water for the following situations: b. Before and after direct contact with residents;...d. Before performing any non surgical invasive procedure;...l. After contact with objects in the immediate vicinity of the resident...9. Use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice...." 3.1-18(a) 3.1-18(b)(1)		documentation, as needed to assure compliance. DON/Designee will perform medication pass with the nurses/QMA to ensure proper handwashing technique is being performed during medication glucometer checks/insulin injections. Medication pass observations will be performed twice weekly. All staff will be educated on infection control practices and covid 19. All non-compliance issues will be reviewed and discussed in QAPI monthlyx3. The QA Committee will review the data to ensure that threshold for compliance of 95% is met. If threshold is not met an action plan will be developed. The QA tool will be on-going. **Compliance Date: 4-28-2023**	
F 0888 SS=C Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of			

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	all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination			

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	must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as			

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	defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on record review and interview, the facility	F 0888	**F888 COVID-19 Vaccination of**	04/28/2023

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	155746	A. BUILDING 00 B. WING	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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	failed develop and implement comprehensive policies and procedures to prevent COVID-19 related to the lack of mitigation plans for additional precautions for unvaccinated employees in the Employee COVID-19 Vaccination Policy. This had the potential to affect all 36 residents in the facility. Finding includes: The Employee COVID-19 Vaccination Policy was reviewed on 4/11/23. The policy lacked additional COVID-19 mitigation plans for unvaccinated employees. Interview with the Infection Control Nurse, on 4/6/23 at 10:10 a.m., indicated all staff were required to wear surgical masks regardless of vaccination status, they did not require additional measures for unvaccinated staff. Interview with the Director of Nursing, on 4/11/23 at 2:00 p.m., indicated she was unaware the policy was required to have additional measures for unvaccinated staff.		**Facility Staff** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Covid19 vaccination policy was put in place to include a mitigation plan for additional precautions for unvaccinated employees. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents and staff have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not occur;** Staff will be in-serviced on COVID 19 policies with regards to unvaccinated employees. New team members will be educated during orientation on COVID 19 policies with regard to unvaccinated employees. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put in place; Don/Designee will audit records to ensure all unvaccinated employees and new hires have received additional education. DON/Designee will also review COVID 19 policies weekly as need to ensure compliance. All non-compliance issues will be reviewed and discussed in QAPI monthly x3 or until compliance is met. **Completion date: 4-28-2023**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00404821. Complaint IN00404821 - No deficiencies related to the allegations are cited. Survey dates: April 3, 4, 5, 6, 10, and 11, 2023. Facility number: 000539 Residential Census: 16	R 0000	**The preparation and execution of the Plan of Correction does not constitute admission or agreement, by the provider of the alleged deficiencies.** **We are requesting a desk review do too the low scope and severity.**	

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/13/23.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure a treatment order was in place and implemented for a resident with a pressure ulcer for 1 of 5 resident records reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 4/10/23 at 11:40 a.m. Diagnoses included, but were not limited to, respiratory failure and atrial fibrillation. The resident was admitted on 1/26/23 with a stage 2 pressure ulcer on his right buttocks. A Physician's Order, dated 4/5/23, indicated to apply a mepilex dressing to the pressure ulcer and change every three days. Discontinue the mepilex when cavilon cream comes in. A Physician's order, dated 4/8/23, indicated to apply cavilon barrier cream to area once daily. The April 2023 Treatment Administration Record (TAR) indicated the mepilex dressing had been changed on 4/3/23. There were no additional treatments documented. The TAR indicated on	R 0241	**R 241 (Health Services-Offense)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 2 A wound assessment was completed. The physician was notified and orders were received. R2 denied pained and no deterioration was noticed. Wound care was provided as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	04/28/2023

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	4/8, 4/9, 4/10 and 4/11/23 the cavilon cream had not been available. Interview with the Director of Nursing, on 4/11/23 at 12:15 p.m., indicated the nurse had changed the dressing on 4/6/23, but had not documented it. They had corrected the orders to read "until the cavilon cream comes in."		All residents with wounds has a potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not occur;** A wound sweep has been completed. A chart audit has been conducted to assure all residents with wounds have current treatment orders in place. The licensed staff will be in-serviced to ensure treatments ordered are in place and implemented per physicians orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place;** The DON/Designee will conduct chart audits 5x per week for x4 weeks then weekly for compliance. All noncompliant issues will be reviewed and discussed in QAPI monthly x3 or until compliance is met.	

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