STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. BUILDING _____ B. WING _____	03/05/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to a ensure the electronic and paper medical chart information matched for 1 of 24 residents reviewed for Advanced Directives. The State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order and POST form indicated DNR status while the current physicians orders stated resident was a Full Code. (Resident 34) Finding includes: On 3/2/2020 at 1:51 p.m., the record for Resident 34 was reviewed. The Out of Hospital Do Not Resuscitate Declaration and Order, dated July 13, 2016, was signed per Resident 34 and by the physician on 7/14/16. The facility Health Care Directives indicated Resident 34 was a Do Not Resuscitate, signed per the POA (Power of Attorney) on 10/2/19. The Indiana Physician order [REDACTED]. The Order Summary Report dated February 17, 2020, indicated, but was not limited to, Full Code dated 5/22/19. On 3/3/2020 at 9:37 a.m., RN 2 indicated Resident 34 was a full code. She then reviewed the paper record and noted the DNR status. RN 2 indicated that Admissions handles that. On 3/3/2020 at 9:40 a.m., the Admissions person indicated sometimes nursing handles that, depends on when it happens, or Social Services. I have no idea. On 3/3/2020 at 9:43 a.m., the Social Services Director (SSD) indicated she filled it out with the family. When she updated forms, she made a copy and put it in the chart, and medical records updates the orders, and puts in the chart when the physician signs. On 3/3/2020 at 9:46 a.m., LPN 3 indicated code status was gone over with the family and/or the resident. They are provided education and if the resident was unable, the information was provided to the family, so they know what they are consenting to. Advance directives go to the physician for signature, back to the facility, and if there was a change, it should be updated on the MAR (Medication Administration Report) to reflect the order. On 3/4/2020 at 2:32 p.m., the Regional Consultant provided the current facility policy, Advance Directives, effective date 8/21/19. The Policy indicated, but was not limited to, the advance directive copy should always remain in the resident's record, protected in a plastic cover, even if the chart is thinned .Residents may revise an advance directive either orally or in writing .the physician must give an order for [REDACTED].
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on record review and interview, the facility failed to provide residents, or the resident's representative, the Notice of Medicare Non-Coverage (NOMNC) for 1 of 3 residents reviewed for SNF (Skilled Nursing Facility) Beneficiary notification. Resident 30 did not receive a NOMNC when the facility initiated the discharge from Medicare Part A Services. (Resident 30) Finding includes: On 3/3/2020 at 3:09 p.m., the records for Resident 30 were reviewed. Resident 30 admitted on MCR (Medicare) A services on 2/12/2020 and was discharged from MCR A services on 2/22/2020. On 3/3/2020 at 3:13 p.m., the Business Office Manager indicated it was an oversight. The MDS (Minimum Data Set) Coordinator was new, and had been instructed to give the NOMNC to all residents discharged from MCR Part A services. On 3/3/2020 at 3:20 p.m., the MDS Coordinator indicated I don't know what happened. She was to give NOMNC with the ABN (Advance Beneficiary Notice of Non-Coverage) a minimum of 2 days before the end date. We will have to do an audit and wasn't sure if others were missed. On 3/3/2020 at 4:22 p.m., the MDS Coordinator indicated they were providing the NOMNC to the other persons affected dated today. On 3/4/2020 at 2:32 p.m., the Business office Manager provided the current facility policy, Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), undated. The Policy indicated, but was not limited to, a medicare provider .must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing must ensure that the beneficiary or representative received the notice and understands that the termination decision can be disputed. 3.1-4(f)(3)
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide notice of transfer to residents or resident representative's as soon as was practicable for 1 of 1 resident's reviewed for hospitalization s. (Resident 39) Finding includes: On 3/2/20 at 10:30 a.m., Resident 39 indicated she had been out to the hospital, but was not sure why she went to the hospital and she thinks she got the bed hold information, but could not remember. On 3/3/20 at 1:38 p.m., Resident 39's record was reviewed. She had [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) dated 12/30/19, indicated Resident 39 was cognitively intact. A progress note dated 10/26/19 at 8:39 p.m., indicated Resident 39 was sent to the emergency room . A admission assessment dated [DATE] indicated Resident the returned to the facility. The record contained no documentation the resident or resident representative was provided written notification of the Notice of Transfer or Discharge. On 3/5/20 at 8:48 a.m., the Social Service Director indicated that she notified Resident 39's representative by phone of the transfer discharge information and bed hold policy. On 3/5/20 at 2:25 p.m., LPN 1 indicated that when a resident is sent to the hospital the transfer discharge information and bed hold are given to the EMT (Emergency Medical Technician). On 3/5/20 at 1:46 p.m., the SDC (Staff Developmental Coordinator) provided the current bed hold policy with an effective date of 5/2/19. The policy indicated but was not limited to: The bed hold policy should be given upon admission, upon transfer of a resident to the hospital (if an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed hold periods and the residents return to the facility to ensure that residents are made aware of a facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility. 3.1-12(a)(8)(D)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on interview and record review, the facility failed to provide bed hold information to residents or resident representative's as soon as was practicable for 1 of 1 resident's reviewed for hospitalization . (Resident 39) Finding includes: On 3/2/20 at 10:30 a.m., Resident 39 indicated she had been out to the hospital, but was not sure why she went to the hospital and she thinks she got the bed hold information, but could not remember. On 3/3/20 at 1:38 p.m., Resident 39's record was reviewed. She had [DIAGNOSES REDACTED]. A quarterly MD'S (Minimum Data Set) dated 12/30/19, indicated Resident 39 was cognitively intact. A progress note dated 10/26/19 at 8:39 p.m., indicated Resident 39 was sent to the emergency room . A admission assessment dated [DATE] indicated Resident the returned to the facility. The record contained no documentation the resident or resident representative was provided written notification of bed hold information. On 3/5/20 at 8:48 a.m., the Social Service Director indicated that she notified Resident 39's representative by phone of the transfer discharge information and bed hold policy. On 3/5/20 at 2:25 p.m., LPN 1 indicated that when a resident is sent to the hospital the transfer discharge information and bed hold policy are given to the EMT (Emergency Medical Technician). On 3/5/20 at 1:46 p.m., the SDC (Staff Developmental Coordinator) provided the current bed hold policy with an effective date of 5/2/19. The policy indicated but was not limited to: The bed hold policy should be given upon admission, upon transfer of a resident to the hospital (if an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed hold periods and the residents return to the facility to ensure that residents are made aware of a facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility. 3.12-(a)(25) 3.12-(a)(26)
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Significant Change Assessment following a fracture for 1 of 2 residents reviewed for fractures. resident sustained [REDACTED]. (Resident 84) Finding includes: On 3/2/2020 at 11:52 a.m., Resident 84 was observed in her bed, upper body dressed, appeared comfortable, pleasant and smiling. On 3/2/2020 at 12:06 p.m., the record for Resident 84 was reviewed. The IDT (Interdisciplinary Team) notes dated 1/24/2020 at 3:43 p.m., indicated resident was transferring from bed to w/c (wheelchair) with stand by assist .when resident put left leg down on the floor, CNA heard a loud pop . The x-ray dated 1/23/2020 indicated, but were not limited to, Impression: the visualized osseous structures demonstrate subacute fractures involving the proximal left fibular shaft, distal left fibular shaft and distal left tibial shaft. Continued close clinical correlation is advised and orthopedic consultation is recommended. Note of Pathological Fracture dated 2/11/2020, indicated Resident 84's fractures involving the left are pathological in nature and due to the disease process [MEDICAL CONDITION], other contributing factors are malnutrition, weight loss, and end of life processes. On 3/4/2020 at 9:51 a.m., the Quarterly MDS (Minimum Data Set) dated 2/8/2020 was reviewed. The assessment lacked indication of other fracture or significant change in condition. On 3/4/2020 at 1:10 p.m., the MDS Regional Consultant indicated a Significant Change Assessment is completed for condition change that does not change/resolve in 14 days. She reviewed the Quarterly assessment completed on 2/8/2020 and indicated Resident 84 had a fracture prior to that assessment, and a Significant Change Assessment should have been completed. On 3/5/2020 during interview beginning at 11:33 a.m., the Administrator indicated the facility did not have a policy for the MDS, they follow the RAI (Resident Assessment Instrument) Manuel. 3.1-31(d)(1)
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately complete the MDS (Minimum Data Set) assessment following a fracture for 1 of 2 residents reviewed for fractures. resident sustained [REDACTED]. (Resident 84) Finding includes: On 3/2/2020 at 11:52 a.m., Resident 84 was observed in her bed, upper body dressed, appeared comfortable, pleasant and smiling. On 3/2/2020 at 12:06 p.m., the record for Resident 84 was reviewed. The IDT (Interdisciplinary Team) notes dated 1/24/2020 at 3:43 p.m., indicated resident was transferring from bed to w/c (wheelchair) with stand by assist .when resident put left leg down on the floor, CNA heard a loud pop . The x-ray dated 1/23/2020 indicated, but were not limited to, Impression: the visualized osseous structures demonstrate subacute fractures involving the proximal left fibular shaft, distal left fibular shaft and distal left tibial shaft. Continued close clinical correlation is advised and orthopedic consultation is recommended. Note of Pathological Fracture dated 2/11/2020, indicated Resident 84's fractures involving the left are pathological in nature and due to the disease process [MEDICAL CONDITION], other contributing factors are malnutrition, weight loss, and end of life processes. On 3/4/2020 at 9:51 a.m., the Quarterly MDS (Minimum Data Set) dated 2/8/2020 was reviewed. The assessment lacked indication of other fracture. On 3/4/2020 at 1:10 p.m., the MDS Regional Consultant reviewed the Quarterly assessment completed on 2/8/2020 and indicated Resident 84 had a fracture prior to that assessment and it was not marked for the fracture. On 3/5/2020 during interview beginning at 11:33 a.m., the Administrator indicated the facility did not have a policy for the MDS, they follow the RAI (Resident Assessment Instrument) Manuel.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a care plan for 1 of 1 resident reviewed for positioning. (Resident 83) Finding includes: On 3/2/2020 at 11:13 a.m., Resident 83 was observed sleeping in a Broda chair (a chair that offer tilt-in-space positioning) sitting in the hallway across from the nurse's station. The resident had a bruise on her right eye area. On 3/2/2020 at 11:39 a.m., CNA 4 and CNA 3 were observed to transport the resident to her room. The CNAs indicated they were going to reposition the resident. CNA 4 elevated the back of the Broda chair. CNA 3 obtained a pillow and placed the pillow under the resident's left shoulder. The Broda chair was returned to the lying position and the resident was transported back into the hallway. On 3/2/2020 at 1:45 p.m., Resident 83 was observed lying in the Broda chair on her back. On 3/3/2020 at 9:24 a.m., Resident 83 was observed to be lying in the Broda chair outside of the nurse's station, sleeping. On 3/3/2020 at 11:15 a.m., Resident 83 was observed to be sleeping in the Broda chair outside of the nurse's station. The resident was lying on her back in the chair. On 3/4/2020 at 9:07 a.m., CNA 2 and the hospice home health aide were observed to transfer the resident to the Broda chair. The back of the Broda chair was reclined. On 3/4/2020 at 2:35 p.m., Resident 83 was observed lying on her back in bed. The clinical record for Resident 83 was reviewed on 3/3/2020 at 2:14 p.m. [DIAGNOSES REDACTED]. The clinical record indicated the resident had a history of [REDACTED]. The clinical record lacked a physician's orders [REDACTED]. The resident lacked a care plan for repositioning in the Broda chair or while in bed. On 3/4/2020 at 1:40 p.m., the Director of Nursing indicated the resident should be repositioned while in the Broda chair. On 3/5/2020 at 11:33 a.m., CNA 2 indicated the resident should be repositioned every two (2) hours while in the Broda chair or in bed. On 3/5/2020 at 11:38 a.m., RN 1 indicated she created the care plans. The resident did not have a policy for the Broda chair or repositioning, but she would be creating one immediately. The current facility policy, Care Planning and Interventions, revision date 7/23/09, provided by the Director of Nursing on 3/5/2020 at 12:07 p.m., indicated the interdisciplinary team would develop an individualized care plan to provide the greatest benefit to the resident. 3.1-35(b)(1)
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents for 2 of 3 residents reviewed for falls. Supervision and effective fall interventions were not in place for a resident, which resulted in a resident receiving a femur fracture and surgical intervention and a resident who obtained a hematoma from a fall. Resident 1 did not receive care by 2 assistance resulting in the resident falling out of bed. (Resident 1, Resident 83) Findings include: 1. On 3/2/20 at 9:52 a.m., Resident 1 indicated she had fell out of bed approximately three weeks ago and sustained a fracture of her right femur. She indicated she had surgery on the leg, a rod was placed in it, and she still had her staples in. The clinical record for Resident 1 was reviewed on 3/3/2020 at 10:51 a.m. [DIAGNOSES REDACTED]. A

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) quarterly MDS (Minimum Data Set) assessment, dated 11/11/19, indicated the resident had no cognitive impairment. The MDS indicated the resident required extensive assist of 2 persons for bed mobility. A care plan, start date 9/3/19, indicated the resident had an ADL (Activity of Daily Living) self-care performance deficit related to disease process, end stage kidney disease, fatigue, and limited mobility. A bed mobility intervention included, but was not limited to, resident requires extensive assist by 2 (two) and use of 1/4 bilateral side rails to turn and reposition in bed routinely and as necessary, start date 7/15/19, revision date 11/24/19. A progress note, dated 2/10/2020 at 7:00 a.m., indicated the resident fell from her bed during a bed check/change at 5:40 a.m. According to the CNA and resident, the CNA was attempting to roll the resident over using the side rail while the CNA was removing the pad under the resident. The resident placed her right leg over her left leg and this caused the resident to fall to the floor. The resident complained of severe left leg pain in her thigh. The resident was assisted into bed by 8 persons and a Hoyer lift (a mechanical lift), and a portable x-ray was ordered. A progress note, dated 2/10/2020 at 11:41 a.m., indicated the resident had her left leg and knee x-rayed and the resident had a broken leg. A progress note, dated 2/10/2020 at 4:06 p.m., indicated the resident had fell out of bed this a.m. Reported that an x-ray of left leg had been ordered. Resident had a left distal femur fracture. The x-ray technician did not want to move the resident's leg for any other x-rays at that time. Findings were called and the report sent to the physician's triage service. Order was received to transfer the resident to the emergency room for evaluation and treatment. The resident was notified of the physician's orders [REDACTED]. The resident's family was notified An IDT (Intradepartmental Team) note, dated 2/15/2020, included, but was not limited to, Resident 1 had a fall resulting in a left femur fracture. She was sent to the hospital and had a rod placed on 2/12/2020. She returned to the facility on [DATE]. Root cause analysis performed and staff was interviewed. CNA involved in incident did not follow plan of care. Resident 1 was a bed assist of 2 persons and CNA was only staff in room turning resident. The bed the resident was on was inspected and in proper working order. A new bed was placed in the resident's room that was wider and more conducive to the resident habitus and moisture state. An x-ray report, dated 2/10/2020, of the left femur included, but was not limited to, the following: Findings: Comminuted [MEDICAL CONDITION] femoral diaphysis extending into the distal metaphysis. There is dorsal displacement of the distal fragment, as well as overriding and anterior angulation. Proximal femur is intact. Normal alignment of the left hip joint. Diffuse loss of bone mineral density. A Fall Risk Evaluation, dated 2/10/2020 at 8:01 a.m., indicated the resident had a score of 14, which indicated the resident was a high risk for falls. A Fall Risk Evaluation, dated 2/4/2020 at 6:00 p.m., indicated the resident had a score of 14, which indicated the resident was a high risks for falls On 3/4/2020 at 10:21 a.m., LPN 2 indicated the resident had fallen out of bed when pericare was being provided. She had turned herself to side causing her leg to slip off and she rolled out of bed. She indicated the resident required surgery and had several staples in her leg which will be removed next week. On 3/4/2020 at 2:00 p.m., the DON (Director of Nursing) indicated the resident was a 2 person assist for bed mobility and had only 1 CNA assisting her to turn when she rolled out of bed, fracturing her left femur. She indicated the staff had been educated regarding following the care plans of the residents. 2. On 3/2/2020 at 11:13 a.m., Resident 83 was observed to be lying in a broda chair (a chair that offers tilt-in-space positioning). Resident 83 had a bruise to the right eye. The clinical record for Resident 89 was reviewed on 3/3/2020 at 2:14 p.m., [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 2/7/2020, indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident required extensive assist of 2 persons for transfers. An ADL (Activity of Daily Living) care plan, start date 1/6/2020, included, but was not limited to, the following intervention: resident required assist of 2 staff and mechanical lift for transfers, start date 1/6/2020. A history of falls care plan, start date 12/24/19, included, but was not limited to, the following intervention: Call light within reach, start date 12/24/29, revision date 1/6/2020. Assist with ADLs as needed, start date 12/24/19, revision date 1/6/2020. Resident was not to be left in common areas without staff near as the resident would attempt to get up before she will ask for help, start date 2/21/2020. A Fall Risk Evaluation, dated 2/21/2020 at 2:41 p.m., indicated the resident had a score of 22 which indicated the resident was a high risk for falls. A progress note, dated 2/21/2020 at 1:54 p.m., indicated Resident was noted to have laceration to bridge of nose and hematoma to R (right) eyebrow, resident also stated that R shoulder hurt but was able to move without issues. MD (Physician) notified and ordered facial x-ray and x-ray to R shoulder, neuro checks performed per policy. Residents pupils are 3 and react brisk. A facial bones x-ray report, dated 2/21/2020 at 11:08 p.m., included, but was not limited to the following conclusions: No obvious or acutely displaced fracture. A right shoulder x-ray report, dated 2/21/2020 at 11:08 p.m., included, but was not limited to the following conclusion:Mild shoulder arthrosis without radiographic evidence of an acute bony abnormality. On 3/4/2020 at 1:30 p.m., CNA 1 indicated the resident had fallen out of her broda chair in the restorative dining room. She indicated no staff was present in the room when the resident fell . On 3/5/2020 at 9:25 a.m., the Director of Nursing (DON) indicated she had not entered an IDT note regarding the resident's fall. The resident was left unattended in the restorative dining room and fell out of her chair. The staff had been educated no one should be left alone if they were a fall risk. A Root Cause Analysis dated 2/21/2020, provided by the Director of Nursing on 3/5/2020 at 9:37 a.m., indicated At risk for falls no CNA in restorative-spoke with CNAs and nurses regarding no resident who is at risk for falls should be left unattended. The current facility policy, Fall Management, revision date 4/15/19, provided by the DON on 3/5/2020 at 1:47 p.m., included, but was not limited to, the facility must ensure that the resident's environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents. 3.1-45(a)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary services for 1 of 1 residents receiving a respiratory treatment. A resident was left alone during a nebulizer treatment. (Resident 63) Finding includes: On 3/4/20 at 8:00 a.m., LPN 2 was observed to enter Resident 63's room and obtain Resident 63's vital signs and auscultate Resident 63's lung sounds. LPN then set up the nebulizer machine and gave the nebulizer mask to resident 63, who put it over her trach. LPN 2 then left the room. LPN 2 indicated Resident 63 had an order to self administer her nebulizer treatment. On 3/5/20 at 11:25 p.m., Resident 63's record was reviewed. [DIAGNOSES REDACTED]. An Admission MDS (Minimum Data Set), dated 1/16/20 indicated Resident 63's cognition was severely impaired. Resident 63's current orders were reviewed and included, but were not limited to Ipratroplum [MEDICATION NAME] solution 0.5-2.5(3) mg(milligram)/ml 3 ml (milliliter) inhale orally via nebulizer four times a day. On 3/05/20 at 10:49 a.m., the DON indicated Resident 63 did not have an order to self administer her nebulizer treatment, and the nurse should have stayed in the room during the treatment. On 3/5/20 at 11:15 a.m., the current nebulizer policy was provided by the Regional Nurse Consultant. The policy had a revision date of 9/2/18. The policy included, but was not limited to, instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughput treatment .monitor for medication side effects, including rapid pulse, restlessness, and nervousness., stop the treatment and notify the physician if their pulse increases 20 percent above baseline or if the resident complains of nausea or vomits, tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup . 3.1-47(a)(6)
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview, and record review, the facility failed to post the nursing staff information for 2 of 4 days of the survey. (March 2 and March 3, 2020) Findings include: On 3/2/2020 at 7:51 a.m., the Posted Nurse Staffing was observed in the hall across from the Administrator's office. The posting was dated February 29, 2020. On 3/3/2020 at 9:10 a.m., the Posted Nurse Staffing was observed in the hall across from the Administrator's office. The posting date was March 2, 2020. The same was observed at 10:45 a.m., and 12:18 p.m., On 3/5/2020 at 11:28 a.m., Staff Development Coordinator indicated the posted nurse staffing should be posted every morning even on the weekends. The current facility policy, Staffing, effective date 4/24/29, provided by the Director of Nursing on 3/5/2020 at 1:47 p.m., indicated the facility must post the nurse staffing data on a daily basis at the beginning of each shift.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide an environment that enhanced the quality

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of life for a resident with dementia for 1 of 1 residents reviewed for dementia care. A resident did not receive adequate stimulation to reduce the decline of his cognitive status. (Resident 80) Finding includes: On 3/3/2020 at 9:09 a.m., Resident 80 was observed in a recliner in his room, dressed in a gown, with a blanket over his lap. Resident 80's eyes were closed and the TV was on in the room. On 3/3/2020 at 11:47 a.m., Resident 80 was observed in a recliner in his room, dressed in street clothing, and eyes open. He was nonverbal with CNA 7 who entered and tried to engage him. CNA 7 was observed to ask Resident 80 if she could adjust his brace to his right arm, and perform tasks in the room. Resident was observed to have a paper napkin in his lap, folding it and unfolding it, with few words spoken. CNA 7 and CNA 8 assisted Resident 80 into his wheelchair and propel him out of his room toward the dining room. On 3/3/2020 at 1:54 p.m., the medical record for Resident 80 was reviewed. [DIAGNOSES REDACTED]. Care plans included, but were not limited to, Resident 80 has a communication problem related to dementia, dated 2/10/2020. Interventions included, but were not limited to, be conscious of resident position when in groups, activities, dining room to promote proper communication with others, dated 2/10/2020. Monitor/document frustration level. wait 30 seconds before providing resident with word, dated 2/10/2020. Resident 80 has impaired cognitive ability / impaired thought processes related to dementia. Interventions included, but were not limited to, engage the resident in simple structured activities that avoid overly demanding tasks., initiated date 2/10/2020, revision on 3/5/2020. The care plans lacked an activities care plan. On 3/4/2020 at 7:49 a.m., Resident 80 was observed in his recliner, dressed in street clothing, with his eyes closed. On 3/4/2020 at 1:32 p.m., Resident 80 was observed in his recliner being assisted to eat. CNA 8 indicated Resident 80 had had his brief off and had to be taken care of before his meal could be eaten. On 3/5/2020 at 8:56 a.m., the Activities Director indicated they did the activities assessment with Resident 80's wife, and Resident 80 would like to go to some activities. He would check with Resident 80 daily and he hasn't been willing to get out of his chair. He wanted to engage Resident 80 today during the men's club with a simple card game he could assist him with. The Activities Director verified there was not an activities care plan in place. On 3/5/2020 at 10:15 a.m., the Activities Director provided a care plan, the resident has little or no activity involvement related to disinterest and dementia, dated 3/5/2020, initiated per the MDS Coordinator. Interventions included, but were not limited to, encourage activities that require limited decision making due to dementia, initiated 3/5/2020. Observe for impact of medical problems on activity level, initiated on 3/5/2020. The resident needs assistance/escort to activity functions, initiated on 3/5/2020. The resident's preferred activities are: watching TV snacks coffee one on one conversation (sic), date initiated 3/5/2020. On 3/5/2020 at 1:47 p.m., the Director of Nursing provided the current facility policy, Dementia - Clinical Protocol, revised date 4/4/18. The Policy included, but was not limited to, the staff, with the physician's input will stage dementia and identify prognosis .will jointly define the decision-making capacity of someone with dementia, including the extent to which the individual can participate in making everyday decisions and considerations about healthcare treatment choices .for an individual with confirmed dementia, the staff and physician will identify a plan to maximize remaining function and quality of life .Staff will be provided with mandatory minimum of dementia related education. 3.1-37(a)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation,interview, and record review, the facility failed to provide a safe and sanitary environment for the food storage and food preparation area in 2 of 2 observations. A thermometer was broke in the walk-in freezer, temperature logs for the milk cooler and walk-in freezer were not obtained for the month of February, dirt and debris was observed on the floor, the paper towel dispenser was soiled, and hand hygiene was not performed. (Kitchen) Findings include: During an observation of the kitchen on 3/2/2020 from 7:58 a.m. through 8:30 a.m., the following were observed: 1. The paper towel dispenser over the hand-washing sink had brown dirt on it where the towels were dispensed. 2. The floor had dirt and debris on it and was sticky in areas. 3. The walk-in freezer had a broken thermometer in it. 4. Dietary Aide 1 was observed to be serving the breakfast meal. She washed her hands, removed a small piece of paper towel as the paper towel dispenser was not working correctly, and dried her hands. She turned the water faucet off with her bare hands, prior to returning to the steam table. 5. The milk cooler temperatures had not been obtained for the entire month of February, 2020, nor on March 1, 2020. 6. The walk-in freezer temperatures had not been obtained for the entire month of February, 2020, nor on March 1, 2020. On 3/3/2020 at 9:15 a.m., the Dietary Manager indicated he had educated the kitchen staff regarding obtaining the temperatures of the refrigerators, freezers, and milk cooler. He indicated the walk-in freezer had a new thermometer in it. During an observation of the kitchen on 3/3/2020 from 9:33 a.m., through 12:05 p.m., the following was observed: 7. The floor was soiled with dirt and debris. 8. The stove top was soiled with burnt food and food particles on it. 9. The food processor had scrambled egg on the machine and a light colored substance going down the side of the processor machine. 10. The table with the food processor had a yellow liquid and food particles on the top of it. 11. When placing the pureed fish into a pan, Cook 1 was observed to drop the processor lid into the pan, indicating, That is one way to get it off of there (lid). 12. During the pureeing process, Cook 1 was observed to perform hand hygiene, thumb through the recipes, obtain 3 clean pans, place on oven mitts, and obtained a pan of cabbage from the oven. She placed the pan of cabbage onto the prep table, removed the oven mitts, uncovered the pan of cabbage, place of pair of gloves on, obtained a scoop from a drawer of utensils, and scooped the cabbage from one pan, placing the cabbage into a clean pan. The prep table was soiled with food particles and liquid throughout the pureeing process. 13. During the pureeing process, Cook 1 was observed to drop one oven mitt onto the floor, pick the mitt up, and place the mitt on a piece of cardboard on a rolling cart. Cook 1 was observed to puree the cauliflower, obtain a spatula from a drawer. She placed the pureed cauliflower into a pan, covered the pan with aluminum foil, labeled the pan, and placed the pan into the steamer. No hand hygiene was observed. On 3/3/2020 at 10:40 a.m., Cook 1 indicated gloves should be removed and hands washed after touching anything in the kitchen. On 3/5/2020 at 11:31 a.m., the Dietary Manager indicated the kitchen floor was cleaned nightly but was swept throughout the day. Tables and equipment should be cleaned when they are soiled and after each use. The current facility policy, Food and Nutrition Services, revision date 7/25/29, provided by the Dietary Manager on 3/5/2020 at 1:47 p.m., indicated the Director of Food Service should keep adequate records of temperature of the refrigeration and dish machine. Provide and document personnel education regarding personal hygiene and food handling sanitation. Ranges and grills should be cleaned as needed. All work surfaces, utensils, and equipment should be cleaned and sanitized after each use. 3.1-21(i)(2) 3.1-21(i)(3)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 1 of 1 residents with observation of glucometer cleaning, 2 of 5 residents reviewed for [MEDICAL CONDITION] screening, 3 of 7 residents observed during personal care. The glucometer was not sanitized according to the manufacturer's recommendations. [MEDICAL CONDITION] screening was not completed annually. Hand hygiene was not performed per guidelines during personal care. (Resident 74, Resident 34, Resident 5, Resident 83, Resident 8, Resident 69) Findings include: 1. On 3/03/20 at 11:53 a.m., LPN 1 was observed to obtain a germicidal disinfectant wipe and wipe the front and back of the glucometer and put the glucometer into a plastic cup to dry. At 11:56 a.m., LPN 1 was observed to use the glucometer to obtain the blood sugar for Resident 74. The disinfectant wipe container was observed and indicated, but was not limited to: to clean , disinfect , and deodorize, use wipe to remove heavy soil, unfold a clean wipe and thoroughly wet surface treated, surface must remain wet for 4 minutes, use additional wipes if needed to assure continuous 4 minute wet contact time. The glucometer surface was not observed to remain wet for 4 minutes. On 3/3/20 at 12:02 p.m., LPN 1 indicated the glucometer was supposed to be wiped for several minutes, then let dry for 3 minutes. 03/05/20 12:15 PM The Regional Nurse Consultant indicated the facility follows the manufacture guidelines for cleaning the glucometer. 2. On 3/3/2020 at 9:15 a.m., the medical record for Resident 34 was reviewed. The record indicated a PPD was given on 1/14/18. On 3/4/2020 at 3:20 p.m., the SDC (Staff Development Coordinator) provided the MAR (Medication Administration Record) for the month of January 2019. The MAR indicated [REDACTED]. The record lacked an Annual [MEDICAL CONDITION] Assessment for Resident 34, regarding the presence or absence of symptoms consistent with [MEDICAL CONDITION]. 3. On 3/4/3030 at 8:14 a.m., the medical record for Resident 5 was reviewed. The record lacked current documentation of administration of a PPD and was last given on 9/11/17 at prior facility residence. On 3/4/2020 at 3:20 p.m., the SDC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. BUILDING _____ B. WING _____	03/05/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) provided the MAR (Medication Administration Record) for Resident 5 for the month of October 2019. The MAR indicated [REDACTED]. The record lacked an Annual [MEDICAL CONDITION] Assessment for Resident 5, regarding the presence or absence of symptoms consistent with [MEDICAL CONDITION]. On 3/4/2020 at 3:35 the DON (Director of Nursing) indicated she would have to look into it. 4. On 3/3/2020 at 9:31 a.m., RN 2 and CNA 6 were observed to push Resident 83 in a reclined Broda (specialized chair that can recline) chair into her room to be repositioned. RN 2 and CNA 6 were observed to apply gloves without hand hygiene and reposition Resident 83, with RN 2 applying a pillow under the left side of Resident 83's torso. RN 2 removed her gloves and washed her hands. CNA 6 removed her gloves and washed her hands. RN 2 pushed Resident 83 in the Broda chair back to the nurses station area. On 3/5/2020 at 11:29 a.m., RN 2 indicated she was to wash her hands when in going in a room before care and when care completed. On 3/5/2020 at 11:30 a.m., CNA 3 indicated she was to wash her hands when going into the room, switch gloves between residents, change gloves if hands become soiled, and she could use hand sanitizer as well. On 3/5/2020 at 11:31 a.m., CNA 6 indicated she was to wash her hands before and after care. 5. On 3/2/2020 at 11:39 a.m., CNA 4 and CNA 3 were observed the reposition Resident 8 in her chair. CNA 4 was observed to attempt to unlock the chair wheel with her bare hand. The resident was transported to her room. Both CNAs applied gloves. No hand hygiene was observed. CNA 3 was observed to drop the resident's pillow onto the floor, pick the pillow up and place it on the resident's bed. She obtained the pillow and placed the pillow under the resident's left shoulder area. The resident was taken out into the hall. 6. On 3/4/2020 at 10:38 a.m., CNA 1 was observed to enter Resident 8's room to perform pericare. CNA 1 obtained a wash basin, removed a plastic bag from her pant's pocket, and apply gloves. No hand hygiene was performed. She opened the resident's brief and placed the soiled brief between the resident's groin area. She obtained a clean wet cloth and gave the cloth to the resident. The resident wiped her perineal area and handed the cloth back to CNA 1. CNA 1 opened a bottle of soap using the soiled washcloth, applied soap to the washcloth, assisted the resident to turn to her right side, and washed the resident's buttocks and rectal area. She obtained a clean wet cloth and rinsed the areas before drying them with a clean towel. The soiled linens were placed onto the floor. She obtained a clean wet cloth and re-wiped the resident's perineum, removed the resident's brief from under her, obtained and applied a clean brief. She applied clean socks on the resident, assisted the resident to sit on the side of the bed, and applied a gait belt. CNA 1 moved the soiled linen from beside the resident's overbed table to the floor in front of the resident's dresser. She moved the resident's wheelchair next to the resident's bed and transferred the resident to her wheelchair. She removed the gait belt from the resident, obtained a blanket from the resident's closet to cover the resident, and removed the resident's nasal cannula and replace the nasal cannula which was connected to a portable oxygen machine. She obtained a bottle of hand sanitizer from the floor and put the sanitizer onto her uniform. She removed the top sheet from the bed, and placed the sheet onto the floor. She obtained a plastic bag from her pant's pocket, removed the trash from the trash can, placed the soiled linens into a plastic bag, and transported the resident into the hall. No hand hygiene was observed before exiting the resident's room. 7. On 3/4/2020 at 2:14 p.m., CNA 1 and CNA 5 were observed to perform a bed bath on Resident 69. CNA 5 obtained plastic bags from her pant's pocket, opened them, and placed the bags onto the resident's bed. Both CNAs donned gloves. No hand hygiene was observed. CNA 1 obtained a basin of water and clean washcloths and towels. She lowered the resident's head of the bed and placed the clean cloths into the basin of water. CNA 1 obtained a clean wet cloth, indicated the water was hot and swung the cloth in the air to cool the cloth prior to washing the resident's face. After washing the resident's face, CNA 1 placed the washcloth onto the floor. She obtained a clean, soapy washcloth and gave the cloth to CNA 5 who washed the resident's left arm, chest, right arm, abdomen, left leg, right lower extremity, perineum, and provided catheter care. The areas were rinsed and dried. CNA 5 changed her gloves and sanitized her hands. CNA 1 applied deodorant to the resident and assisted the resident to her right side. CNA 1 obtained a clean, soapy cloth and washed the resident's back, buttocks, and rectal area. She rinsed and dried the areas, using the towel that was under the wash basin on the overbed table. LPN 2 entered the room to change the resident's sacral dressing. LPN 2 performed hand hygiene and donned gloves. She removed the resident's old dressing, changed her gloves. The wound had a moderate amount of serous drainage. She cleaned the wound with Dakin's solution. A packet of Calcium Alginate fell on to the floor and LPN 2 picked the packet up off the floor. She opened the packet and placed the Calcium Alginate into the wound bed. She removed the packing from the wound. [MEDICATION NAME] was placed into the wound bed and the packing was placed back into the wound. LPN 2 changed her gloves, applied skin prep to the periwound, and applied a foam dressing. LPN 2 changed her gloves, performed hand hygiene, and applied skin prep to the resident's bilateral heels. She removed her gloves and performed hand hygiene. The CNAs placed a clean gown onto the resident. LPN 2 exited the room and disposed of the trash. On 3/5/2020 at 10:22 a.m., CNA 1 indicated hand hygiene should be performed upon entering a resident's room, if gloves or hands become soiled, and prior to exiting the resident's room. Hand should be washed or sanitized after retrieving anything off of the floor. Linens were placed in a pile on the floor when bathing a resident until they can be placed into a plastic bag. On 3/4/20 at 2:27 p.m., the Staff Development Coordinator provided the current policy regarding cleaning and disinfection of the glucometer. The policy had a revision date of 6/28/18 and a review date of 4/15/19. The policy indicated, but was not limited to: the procedure is to be completed in the resident's room after a glucometer check before leaving the room. Dispose of the glucose strip in the biohazard container (sharps container) in the resident's room. Place a barrier (e.g; a paper towel) on the table surface. Place glucometer on the barrier. Remove your gloves, wash or sanitize your hands, put on fresh gloves. Place a second barrier on the table surface, away from and not touching the first barrier. Use a damp paper towel to remove any visible blood or body fluids. Dispose of the paper towel appropriately. Pick up the glucometer from the first barrier and disinfect it with Super Sani-cloth wipe or an equivalent product that kills [MEDICAL CONDITION] and blood-borne pathogens. Follow the manufactures guidelines for wet time when applying disinfectant. Pay close attention to the strip holder area and be sure to not oversaturate the area. Place glucometer down on second barrier. Allow enough time to dry per the manufacturer instructions. Dispose of the first barrier. Remove your gloves and wash or sanitize your hands. After the glucometer is dry, throw away the second barrier and put the glucometer away. Follow hand hygiene protocol. The current facility policy, Handwashing/Hand Hygiene, revision date 3/1/16, provided by the Director of Nursing on 3/5/2020 at 12:07 p.m., indicated employees must wash their hands between 40 and 60 seconds using antimicrobial or non-antimicrobial soap and water before and after direct resident contact, before and after assisting a resident with personal care, upon and after coming in contact with a resident's intact skin, after handling soiled or used linens .,and after removing gloves. 3.1-18(b)(1) 3.1-18(l)