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 _____	**07/23/2020**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a thorough investigation related to an allegation of abuse for 1 of 8 residents reviewed for abuse. (Resident J) Finding includes: On 7/22/2020 at 9:02 a.m., the record for Resident J was reviewed. The MDS (Minimum Data Set), dated 4/24/2020, indicated Resident J required extensive assist for bed mobility and dressing, and supervision for eating. The Admission MDS, dated [DATE], indicated moderate cognitive impairment. The record lacked documentation of allegation of abuse for 3/25/2020. An IDT (Interdisciplinary Team) note dated 3/31/2020 at 6:05 p.m. indicated, but was not limited to, On 3/25/2020 Resident J reported CNA punched her leg to wake her . On 7/22/2020 at 9:41 a.m., the Social Services Director (SSD) indicated they are supposed to put any information on a concern card for allegation of abuse. The Administrator and the Social Services Director would talk to the resident, do a care conference to tell family what was found. Care conference notes should be in the medical record, in progress notes, and she was unaware what the previous SSD was documenting due to she hadn't found much in the medical record. On 7/22/2020 at 10:15 a.m., the Director of Nursing indicated they have been putting information in the risk management area and the surveyors are supposed to have access to the information. There should have been a concern card, but she had not seen one for the allegation of abuse. She indicated there were no Social Services notes following the allegation on 3/25/2020 and there should have been. On 7/22/2020 at 12:00 p.m., Resident J was interviewed. She indicated she didn't know who she (employee) was, but they (facility) had found out by reviewing the films. She had talked to the DON and she knew what was going on and had no more problems like that. On 7/23/2020 at 10:41 a.m., the Director of Nursing indicated she had talked to several residents but did not type up a list. She indicated they had talked to everyone on that assignment, talked to staff, and provided education for the employee involved. She had talked to the resident in private and sent CNA 2 home. She had reported to the sheriffs office, who interviewed the resident and CNA 2 at her home. No charges were filed. She indicated she was aware there were only 2 residents interview statements available and documented. On 7/23/2020 at 1:28 p.m., the Director of Nursing provided the Risk Management report, dated 3/25/2020 7:30 a.m. The report indicated but was not limited to, Resident alleges CNA punched her in her right thigh .Immediate action taken .Social services to provide psychosocial support .oriented to person, oriented to place .confused, drowsy, impaired memory, sedated . Each page was stamped with Privileged and Confidential - Not Part of the Medical Record - Do not Copy. On 7/20/2020 at 2:30 p.m., the Director of Nursing provided the facility policy, Protection of Residents: Reducing the Threat of Abuse & Neglect, dated 5/15/2020. The Policy included, but was not limited to, it is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated .Interviews other residents who received care or services from the alleged perpetrator. This Federal tag relates to Complaint IN 520, IN 880, IN 297, & IN 331. 3.1-28(d)
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, record review, and interview, the facility failed to monitor, thoroughly assess and implement interventions for 1 of 4 residents reviewed for falls. Resident K fell twice in a 2 hour period, the second fall resulted in multiple fractures requiring surgical intervention; failed to monitor Resident G for behavior for elopement and exit seeking for 1 of 1 residents who left the building unattended. (Resident K, Resident G) Findings include: 1. On 7/22/2020 at 10:34 a.m., the record for Resident K was reviewed. [DIAGNOSES REDACTED]. other part of head. The MDS (Minimum Data Set) had an entry tracking record, dated 4/10/2020. The resident was admitted [DATE], discharged to hospital on [DATE], and readmitted to the facility on [DATE]. The Admission MDS (Minimum Data Set), dated 4/25/2020, indicated, but was not limited to, extensive assist of 2 or more staff members for bed mobility and transfer, dependent for toileting with assist of 2 staff, and extensive assist of 1 for eating. Baseline care plan, dated 4/10/2020 at 6:00 p.m., indicated at risk for falls. Interventions included assist with adls (activities of daily living), call light in reach, complete fall risk assessment, and orient resident to room. Additional risks included urinary incontinence, respiratory infection, and at risk for alteration in psychosocial well-being due to visitation restrictions. Care plans included, but were not limited to: Resident K was risk of falls related to personal history of falls, [DIAGNOSES REDACTED]. Goal: Resident K will not sustain serious injury requiring hospitalization through the review date, date initiated 4/18/2020. Interventions included, but were not limited to,anticipate and meet the resident's needs, date initiated 4/12/2020. Assist with ADLs (Activities of Daily Living) as needed, date initiated 4/11/2020. Call light within reach, date initiated 4/11/2020. Complete fall risk assessment, date initiated 4/11/2020. Orient resident to room, date initiated 4/11/2020. Provide appropriate footwear non-skid socks when ambulating or mobilizing in w/c, date initiated 4/12/2020. Pt (sic) (Physical Therapy) evaluate and treat as ordered or PRN (as needed), date initiated 4/12/2020. Resident has had an actual fall with serious injury related to Poor Balance, Poor communication/comprehension, Psychoactive drug use, unsteady gait, date initiated 4/12/2020. Goal: Resident K orbital fx (fracture), left wrist fx, left hip fx will show signs of healing by review date, date initiated 4/12/2020. . The resident has a left [MEDICAL CONDITION] and a left wrist fracture and is at risk for complications, date initiated 5/4/2020. Resident K expresses discomfort r/t (related to) history of [MEDICAL CONDITION] and [DIAGNOSES REDACTED]. Progress notes indicated on 4/11/2020 at 20:20 (8:20 p.m.) Event Note Text: RN observed resident lying on her back in her room when she was walking down hallway area. W/C was approximately a (sic) 1 foot away from her RN had observed resident sitting in her W/C 10-12 minutes prior to incident. Moderated (sic) amount of blood noted on the floor next to resident. Resident had approximately 2-3 cm (centimeter) laceration on left eyebrow area. Left eye slight discolored and swollen shut. Residents right eye open but not verbally responsive. Ice pack applied to laceration. (Hospital name) Nursing Triage notified of event and current status. Triage notifying MD on Call. 8:35 p.m. (family name) residents son notified of status and waiting for return call from MD. 8:40 p.m. Triage called with orders from (MD name) to send to (hospital name) . B/P (blood pressure) 179/105, P (pulse) 84, R (respirations) 18. The MDS tracking record, Entry, was dated 4/18/2020. Progress note dated 4/19/2020 at 10:13 a.m., .fractured left hip, left wrist and left orbital, from previous fall here at (facility name) .pneumonia . On 7/22/2020 at 11:22 a.m., Resident K was observed lying in bed with eyes closed, oxygen per nasal cannula in place, a fall mat at bedside, and Broda chair at foot of bed. On 7/23/2020 at 8:02 a.m., Resident K was observed lying in bed with head of bed elevated, oxygen per nasal cannula in place, eyes closed with breakfast set up in front of her untouched, and opened her eyes briefly when addressed, remained non verbal. On 7/23/2020 at 8:25 a.m., LPN 1 indicated she was working the shift when Resident K had fallen and went to the hospital. She had history of falling at home and had fell 2 times in the facility, the second time with injuries. She would get up by herself, had dementia, and needed reminders. She didn't use the call light. On 7/23/2020 at 10:23 a.m., the Director of Nursing was interviewed while

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) she was providing information from her computer, the surveyor did not have access to the risk management category in the computer system. It was a glitch and the surveyors should have access. She indicated Resident K had fallen on 4/11/2020 at 6 p.m. and at 8:20 p.m. On 7/23/2020 at 10:27 a.m., the Director of Nursing indicated there were no nurses notes regarding the fall at 6 p.m. in the progress notes or assessments in the medical record. The information was in the Risk Management area. The Risk Management information was not part of the medical record. On 7/23/2020 at 1:28 p.m., the Director of Nursing provided the Risk Management report dated 4/11/2020 at 6:00 p.m., for Resident K. The Risk Management notes indicated, but was not limited to, Nursing Description: Resident K was found on buttocks side of wheel chair, stated I fell backwards, Resident Description: I fell backwards down on the floor, was going outside. Immediate Action Taken - Description: no signs of injuries, assist of two back in wheel chair for her supper . Mental Status: oriented to person .Mobility: Wheelchair bound .Predisposing Environmental Factors: other .Predisposing Physiological Factors: confused, current UTI (urinary tract infection), impaired memory .Predisposing Situation Factors: admitted within last 72 hrs .family notified 4/11/2020 at 8:07 p.m., physician notified at 8:03 p.m. The Risk Management report was stamped at the bottom of each page: Privileged and Confidential - Not part of the Medical Record - Do not Copy. The Risk Management report for Resident K, dated 4/11/2020 at 8:20 p.m., indicated, but was not limited to, Incident Description - Nursing Description: RN observed resident lying on her back in her room when she was walking down the hall. W/C was approximately 1 foot away from resident. RN had observed resident sitting in her W/C 10-12 min (minutes) prior to incident. Moderate amount of blood noted on floor next to resident. Resident left eye swollen shut. Right eye open but no (sic) verbally responsive. Immediate Action Taken: Resident assessed for injury. Resident had approximately 2-3 laceration on left eyebrow area. Ice pack applied. Left eye discolored and swollen shut. (Hospital name) Nursing Triage notified. Received orders to send resident to (hospital name) ER (emergency room) for evaluation. Resident taken to Hospital? marked N. Injuries Observed at Time of Incident: Bruise face, Bruise left wrist, Laceration top of scalp. Level of Consciousness: (blank) .Injuries Report Post Incident: no injuries observed post incident .Predisposing Physiological Factors: confused, incontinent, current UTI, impaired memory .Predisposing Situational Factors: admitted within last 72 hours, ambulating without assist .Other info (information): resident has a history of Alzheimer's, dementia, depression, anxiety, bilateral pneumonia, and UTI. Resident also has a history of osteopenia .Witnesses: no witnesses found .DON (Director of Nursing) notified 4/11/2020 at 8:20 p.m., physical notification 8:30 p.m., and family member notification 8:35 p.m. The Risk Management report was stamped at the bottom of each page: Privileged and Confidential - Not part of the Medical Record - Do not Copy. On 7/21/2020 at 2:18 p.m., the Director of Nursing indicated they assess the resident from head to toe, obtain vital signs, do neuro (neurological) checks if unwitnessed, notify the physician, family, Director of Nursing, do a risk management section, complete a pain assessment, fall assessment, and put on pertinent charting for 72 hours when a fall occurs. The resident's permanent clinical record lacked neurological checks beginning with unwitnessed fall date 4/11/2020 at 6 p.m., documentation of fall which occurred at 6 p.m., and interventions to prevent further falls. On 7/23/2020 at 3:03 p.m., the Director of Nursing provided the current facility policy, Fall Management, issues 6/4/2020. The Policy indicated, but was not limited to, Purpose - to promote patient safety and reduce patient falls by proactively identifying, care planning, and monitoring of patients' fall indicators. The facility will assess the resident upon admission/readmission, quarterly, and with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls .Residents will be assessed for fall indicators upon admission, readmission, quarterly, change in condition and with any fall utilizing the Fall Risk Assessment UDA (User Defined Assessments). 2. On 7/21/2020 at 9:40 a.m., the record for Resident G was reviewed. [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set), dated 1/7/2020, indicated moderate cognitive impairment. The Significant Change MDS, dated [DATE], indicated severe cognitive impairment. Resident G needed extensive assistance with bed mobility, transfer, and dressing, and supervision for mobility and eating. Baseline care plan dated 12/27/2019 indicated, but was not limited to, exit seeking at times, occasionally lost in directions, 15 minute checks, redirection for elopement. Goal: resident will not leave facility unattended through the review date. Interventions: complete elopement risk assessment, encourage to participate in activities to divert from exit seeking behavior, provide for safe wandering - resident is an elopement risk. Care plans included, but were not limited to, Resident G is at risk for elopement related to disorientation to place, history of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly, date initiated 12/29/19, revised on 6/25/2020. Interventions included, but were not limited to, add resident to the Elopement Book, date initiated 1/19/2020. Complete elopement risk assessment, date initiated 12/29/19. Document wandering behavior and attempted diversional interventions in Point Click Care, date initiated 1/19/2020. Encourage Resident G to participate in activities to divert from exit seeking behavior, date initiated 12/29/19 . Psychology Diagnostic assessment dated [DATE] indicated, but was not limited to, Review of Symptoms: exit seeking, suspicious/paranoid, distractibility . note dated 3/11/2020 indicated anxiety, delusions, distractibility, exit seeking, impulsivity, intrusiveness, sundowning, wandering, pacing .note dated 5/26/2020 indicated exit seeking. Psychiatry progress note dated 6/1/2020 indicated, but was not limited to, exit seeking. Elopement Risk Evaluation dated 3/27/2020 indicated, but was not limited to, does the resident have a history of Elopement while at home .exhibits exit seeking behavior (checking doors, windows, setting off alarms etc.), history of leaving facility without supervision, or history of leaving facility without informing staff? Answer: No. Does the resident become agitated when diverted from exits, agitated to being contained within the boundaries of the facility (ie verbal expressions of I'm leaving, let me out, I'm calling the police etc.), or has the resident been heard or observed asking others how to get out of here? Answer: Yes. Resident is at risk for elopement at this time? Answer: Yes. Wandering/Elopement interventions: .Add resident to the Elopement Book .frequent monitoring. Progress note dated 5/30/2020 at 7:27 p.m., 15 minute checks continue .no complaints of discomfort from previous fall. Up and down hallway continually. Confusion, restlessness. Anxious and asking for a ride home. At front door and wanting to go home repeatedly. Close observation until episode passes . Progress note dated 6/1/2020 at 7:18 p.m., Continually walking up and down hallway. Around exits stating she has a court date and needs to leave. Difficulty redirecting . Progress note dated 6/3/2020 9:00 p.m., resident went out the front door at 18:49 (6:49 p.m.). She returned at 19:32 (7:32 p.m.) (Name) resident's daughter notified at 20:34 (8:34 p.m.). Physician notified at 2058 (8:58 p.m.). Resident immediately placed (sic) one on one monitoring. Head to toe assessment. No signs or symptoms of injuries noted. Will continue to (sic) one on one monitoring. Progress note effective date 6/3/2020 at 9:09 p.m., created date 6/4/2020, indicated Resident G's care plan updated and psychosocial support provided immediately for resident. Referrals for more appropriate placement have been made. Due to COVID other facilities can not keep Resident G in isolation and would not assume care. Will have social services follow up in the morning. Weekly Skin Integrity Data Collection report dated 6/4/2020 indicated skin intact. On 7/21/2020 at 2:23 p.m., the Director of Nursing indicated CNA 1 had reported seeing Resident G while driving down the street, stopped and got the resident, and gave her a ride to the facility. She was down the road near (Name of fast food restaurant) On 7/21/2020 at 2:35 p.m., CNA 1 indicated she had returned to work to get her purse, had left thru the traffic light on ST Joseph, had recognized her on the left side of the road, at the corner of (Name of fast food restaurant's) intersection (mileage was 1.4 miles south of the facility). She turned her car around, called her over to the car, and offered to take her back to the facility. She called the facility supervisor and she and the Director of Nursing met her at the car when she pulled in the facility parking lot, and escorted Resident G into the facility. She had not noticed Resident G attempting to exit while she was working her day shift. Risk Management Report, Elopement, provided on 7/23/2020 at 8:00 a.m., was dated 6/3/2020 6:49 p.m., revised on 6/4/2020 10:52 a.m., and indicated Resident G was let out front door exit per (hospice nurse name) . (hospice nurse name) reported Resident G was standing at the front door. He reported she had her purse and mask on. He believed she was a visitor. Resident returned to the facility at 7:32 p.m. . The Report was stamped privileged and Confidential - Not a part of the Medical Record - Do not Copy on each page. On 7/23/2020 at 11:34 a.m., the Director of Nursing indicated Resident G was being monitored every 2 hours for side effects of fall. If they were a new resident, behavior monitoring would be on paper, if they had been there a while, the behavior monitoring was in the MAR. She verified continuous pacing was the only behavior monitoring in the medical record. On 7/23/2020 at 3:03 p.m., the Director of Nursing provided the current facility policy, Behavioral Health Management, last revised date 10/3/2017. The Policy indicated, but was not limited to, promote resident safety, attain highest practicable mental/psychosocial well-being and reduce behavior related events .facility must provide necessary behavioral health care and services which include: ensuring that the necessary care and services are person-centered and reflect the resident's goal of care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. This Federal tag relates to Complaint IN 520, IN 880, IN 297, & IN 331. 3.1-45(a)(2)

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2)
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 record review, and interview the facility failed to provide individualized assessment and monitoring 1 of 1 residents with dementia, and failed to provide interventions, track behaviors, and give routine medications for 1 of 1 resident's with dementia and behaviors A resident did not receive adequate assessment to monitor exit seeking behavior which resulted in elopement, and a resident did not receive medications, interventions or behavior tracking for behaviors. (Resident G, Resident H) Finding includes: 1. On [DATE] at 9:40 a.m., the record for Resident G was reviewed. [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set), dated [DATE], indicated moderate cognitive impairment. The Significant Change MDS, dated [DATE], indicated severe cognitive impairment. Resident G needed extensive assistance with bed mobility, transfer, and dressing, and supervision for mobility and eating. Baseline care plan dated [DATE] indicated, but was not limited to, exit seeking at times, occasionally lost in directions, 15 minute checks, redirection for elopement. Goal: resident will not leave facility unattended through the review date. Interventions: complete elopement risk assessment, encourage to participate in activities to divert from exit seeking behavior, provide for safe wandering - resident is an elopement risk. Care plans included, but were not limited to, Resident G is at risk for elopement related to disorientation to place, history of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly, date initiated [DATE], revised on [DATE]. Interventions included, but were not limited to, add resident to the Elopement Book, date initiated [DATE]. Complete elopement risk assessment, date initiated [DATE]. Document wandering behavior and attempted diversional interventions in Point Click Care, date initiated [DATE]. Encourage Resident G to participate in activities to divert from exit seeking behavior, date initiated [DATE] . Psychology Diagnostic assessment dated [DATE] indicated, but was not limited to, Review of Symptoms: exit seeking, suspicious/paranoid, distractibility . note dated [DATE] indicated anxiety, delusions, distractibility, exit seeking, impulsivity, intrusiveness, sundowning, wandering, pacing .note dated [DATE] indicated exit seeking. Psychiatry progress note dated [DATE] indicated, but was not limited to, exit seeking. Progress note dated [DATE] at 7:27 p.m., 15 minute checks continue .no complaints of discomfort from previous fall. Up and down hallway continually. Confusion, restlessness. Anxious and asking for a ride home. At front door and wanting to go home repeatedly. Close observation until episode passes . Progress note dated [DATE] at 7:18 p.m., Continually walking up and down hallway. Around exits stating she has a court date and needs to leave. Difficulty redirecting . Progress note dated [DATE] 9:00 p.m., resident went out the front door at 18:49 (6:49 p.m.). She returned at 19:32 (7:32 p.m.) (Name) resident's daughter notified at 20:34 (8:34 p.m.). Physician notified at 2058 (8:58 p.m.). Resident immediately placed (sic) one on one monitoring. Head to toe assessment. No signs or symptoms of injuries noted. Will continue to (sic) one on one monitoring, created per DON at 10:05 p.m. Progress note effective date [DATE] at 9:09 p.m., created date [DATE], indicated Resident G's care plan updated and psychosocial support provided immediately for resident. Referrals for more appropriate placement have been made. Due to COVID other facilities can not keep Resident G in isolation and would not assume care. Will have social services follow up in the morning. Elopement Risk Evaluation dated [DATE] indicated, but was not limited to, does the resident have a history of Elopement while at home .exhibits exit seeking behavior (checking doors, windows, setting off alarms etc.), history of leaving facility without supervision, or history of leaving facility without informing staff? Answer: No. Does the resident become agitated when diverted from exits, agitated to being contained within the boundaries of the facility (i.e. verbal expressions of I'm leaving, let me out, I'm calling the police etc.), or has the resident been heard or observed asking others how to get out of here? Answer: Yes. Resident is at risk for elopement at this time? Answer: Yes. Wandering/Elopement interventions: .Add resident to the Elopement Book .frequent monitoring. The MAR (Medication Administration Record) dated [DATE] contained: Observe Resident Every 2 hours Fall Risk intervention, order dated [DATE], and was signed per nursing staff. The record lacked monitoring for exit seeking behavior. On [DATE] at 2:35 p.m., CNA 1 indicated she had returned to work to get her purse . She had not noticed Resident G attempting to exit while she was working her day shift. On [DATE] at 9:41 a.m., the Social Services Director (SSD) indicated she was unaware what the previous SSD was documenting due to she hadn't found much in the medical record. On [DATE] at 11:34 a.m., the Director of Nursing indicated Resident G was being monitored every 2 hours for side effects of fall. If they were a new resident, behavior monitoring would be on paper, if they had been there a while, the behavior monitoring was in the MAR. She verified continuous pacing was the only behavior monitoring in the medical record. 2. On [DATE] at 11:25 a.m., Resident H's record was reviewed. The [DIAGNOSES REDACTED]. An Admission MDS (Minimum Data Set) dated [DATE] showed Resident H cognition was severely impaired. The MDS indicated no behaviors were exhibited for the assessment period. The resident was a 2 assist for transfer and toileting. Resident H was admitted to the facility on [DATE] and expired at the facility on [DATE]. Care plans were reviewed and included but were not limited to: The resident uses [MEDICAL CONDITION] medications ([MEDICATION NAME]) related to disease process [MEDICAL CONDITION] with behavioral disturbance. Interventions: observe for side effects and effectiveness every shift, consult with pharmacy, MD, to consider dosage reduction when clinically appropriate at least quarterly, discuss with MD, family, re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, observe for and report as needed any adverse reactions of [MEDICAL CONDITION] medications : unsteady gait, tardive dyskinesia, EPS (shuffling gait, ridged muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, [MEDICAL CONDITION], loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. The initiated date was [DATE]. The resident has ADL (activity of daily living) self-care deficit performance related to dementia: Interventions: Bathing/showering : The resident requires dependent care by (2) staff with bathing and or showers. The resident requires assistance of 1 staff to turn and reposition in bed. The resident requires assistance of 1 to dress. The resident is supervision and cueing as needed by 1 staff for eating. The resident requires assistance of 1 staff for personal hygiene and oral care. Check and change before or after meals, upon rising, and at hour of sleep,every 2 hours in the night, and as needed. Offer and encourage to toilet. The resident requires assistance by (2) staff to move between surfaces. The initiated date was [DATE]. The resident is at risk for alteration in psychosocial well -being due to visitation restrictions related to COVID-19 precautions. Interventions: Encourage or facilitate alternative ways of communication with friends and family, observe for changes in mental status caused by situational stressors and report to physician as appropriate, observe for psychosocial changes and report to physician as appropriate, provide opportunities to express feelings related to situational stressors. The initiated date was [DATE]. The record lacked a care plan and interventions specific to dementia with behaviors. The following progress notes were reviewed and included, but were not limited to: On [DATE] at 11:38 a.m. Resident H was hitting his fist in his hand at a female CNA that was helping him not fall to the floor. No interventions for behavior were found in his record. On [DATE] at 7:36 p.m., a note indicated the resident was hard to redirect, and pushed at staff trying to help him back in his wheelchair for safety, unsteady gait noted, shuffle feet .No intervention were listed for behaviors. On [DATE] at 8:00 p.m., a note indicated the resident was trying to roll himself into other resident's rooms, cursed and swung at the staff, and refused to take his medications or have his blood sugar checked. The notes indicated the staff could not redirect, and the resident is easily agitated and can't be redirected. The note indicated will continue to monitor. A progress note dated [DATE] at 6:45 a.m., indicated the resident refused to allow staff to provide care. A progress note dated [DATE] at 8:52 a.m., indicated the resident is agitated and rejects care. A progress note dated [DATE] at 7:19 p.m., indicated the resident and his roommate were involved in a water throwing fight with their drinks, and that the residents were separated. A progress note dated [DATE] at 8:52 a.m., indicated the resident frequently gets agitated and rejects care. A progress note dated [DATE] at 8: 36 p.m., indicated the resident had to be removed from other resident rooms today multiple times. He was redirected with latching puzzle. A Progress note dated [DATE] at 7:39 p,m., indicated the resident was constantly trying to grab water pictures(sic), med pass, and other items off the medication cart and that trash had to be emptied at routine intervals to keep the resident from digging thorough the trash. Staff tried to redirect him. The progress notes did not give information why the medication was held. Physicians orders were reviewed for March and [DATE]. The orders included, but were not limited to: [MEDICATION NAME] tablet (antipsychotic) 25 mg (milligrams) give 12.5 mg by mouth two times a day related to [MEDICAL CONDITION] with behavioral disturbance start date of [DATE], discontinue date of [DATE]. [MEDICATION NAME] tablet 25 mg

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) give 25 mg by mouth two times a day related to [MEDICAL CONDITION] with behavioral disturbance, order date [DATE], discontinue date [DATE]. [MEDICATION NAME] tablet 25 mg give 25 mg by mouth in the morning related to major [MEDICAL CONDITION] recurrent severe with psychotic symptoms, start date [DATE], discontinue date [DATE]. [MEDICATION NAME] tablet 50 mg give 50 mg by mouth at bedtime related to major [MEDICAL CONDITION], recurrent severe with psychotic symptoms, start date [DATE], discontinue date [DATE]. Donepazil HCI (Alzheimers medication) tablet 5 mg give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION] started date [DATE], discontinue date [DATE]. [MEDICATION NAME] tablet (antidepressant) 10 mg give 10 mg by mouth one time a day related to major [MEDICAL CONDITION], recurrent severe without [MEDICAL CONDITION] features. start date of [DATE], discontinue date of [DATE]. The following orders were on the EMAR (electronic medication administration record) for nursing to record behaviors: Monitor resident for agitated enter # of episodes/shift every shift start date of [DATE], discontinue date of [DATE]. Enter outcome code for agitated intervention- I- improved, S-Same W-worsened every shift, start date [DATE], discontinue [DATE]. For agitated: enter ,[DATE] for nonpharmological interventions tried prior to medication 1- 1 on 1, 2 -activity, 3- adjust room temperature, 4- backrub, 5- change position, 6- give fluids, 7- give food 8- redirect, 9- refer to nurses notes, 10- remove resident from environment, 11- return to room [ROOM NUMBER]- toilet, start date of [DATE], discontinue date of [DATE]. The record lacked tracking of interventions or behaviors until [DATE]. The [DATE] EMAR (Electronic Medication Administration Record) was reviewed. The following dates had a code of 7(Hold/see progress notes) for the a.m. dose of [MEDICATION NAME] 12.5 mg : ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. April EMAR was reviewed and the following dates had a code of 7 for the a.m. dose of [MEDICATION NAME] 25 mg : ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. On [DATE] at 11:50 a.m., the DON indicated she did not know why the medication was held, and that it did not show why in the progress notes. She further indicated it was a routine drug and should have been given, and that the resident came to the facility on [MEDICATION NAME] due to aggressive behaviors. She said behavior tracking should have been done before [DATE] and she thought it may have been done on paper charting before [DATE]. She further indicated behavior tracking should be done on resident's who take an antipsychotic medication. The Residents closed paper record was reviewed and no behavior tracking was found. On [DATE] at 3:03 p.m., the Director of Nursing provided the current facility policy, Behavioral Health Management, last revised date [DATE]. The Policy indicated, but was not limited to, promote resident safety, attain highest practicable mental/psychosocial well-being and reduce behavior related events .facility must provide necessary behavioral health care and services which include: ensuring that the necessary care and services are person-centered and reflect the resident's goal of care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety The facility failed to provide a policy related to dementia care. This Federal tag relates to Complaint IN 520, IN 297, & IN 880. 3XXX,[DATE](a)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain complete medical records that were readily accessible for 4 of 9 residents reviewed. Records did not contain complete and accurately documented assessments, events causing injury, and behaviors. (Resident K, Resident G, Resident J, Resident H) Findings include: 1. On [DATE] at 10:34 a.m., the record for Resident K was reviewed, the record lacked documentation of a fall which occurred on [DATE] at 8:07 p.m. On [DATE] at 10:23 a.m., the Director of Nursing was interviewed while she was providing information from her computer, the surveyor did not have access to the risk management category in the computer system. It was a glitch and the surveyors should have access. She indicated Resident K had fallen on [DATE] at 6 p.m. and at 8:20 p.m. On [DATE] at 1:28 p.m., the Director of Nursing provided the Risk Management report dated [DATE] at 6:00 p.m., for Resident K. The Risk Management notes indicated, but was not limited to, Nursing Description: Resident K was found on buttocks side of wheel chair, stated I fell backwards, Resident Description: I fell backwards down on the floor, was going outside. Immediate Action Taken - Description: no signs of injuries, assist of two back in wheel chair for her supper . Mental Status: oriented to person .Mobility: Wheelchair bound .Predisposing Environmental Factors: other .Predisposing Physiological Factors: confused, current UTI (urinary tract infection), impaired memory .Predisposing Situation Factors: admitted within last 72 hrs .family notified [DATE] at 8:07 p.m., physician notified at 8:03 p.m. The Risk Management report was stamped at the bottom of each page: Privileged and Confidential - Not part of the Medical Record - Do not Copy. 2. On [DATE] at 9:40 a.m., the record for Resident G was reviewed. The medical record lacked documentation of fall dated [DATE] at 3:00 p.m. On [DATE] at 10:08 a.m., the Director of Nursing indicated a QMA (Qualified Medication Aide) had found the resident, and a nurse should have put in a note regarding the incident. On [DATE] at 1:28 p.m., the Director of Nursing (DON) provided the Risk Management Report: Un-witnessed for Resident G for [DATE] at 3:00 p.m. The report indicated the incident location was the dining room, report prepared per the DON Immediate Action Taken, Description: Resident has a linear abrasion to scalp that is bleeding. Manual pressure held until hemostasis achieved. Resident was assessed from head to toe. Resident has slowly brought from lying position to sitting position the BP (blood pressure) was obtained again. Resident was then slowly brought from sitting position up to wheelchair. Family notified, DON notified, and MD notified. Received order from MD (physician) to monitor resident per policy. Ok to use glue to close laceration notes [DATE] IDT Note: Resident laceration to scalp is healing well. Laceration is well approximated with no signs or symptoms of infection. Resident continues on neurological checks. Social Services continues to provide psychosocial support. The bottom of each page was stamped: Privileged and Confidential - Not part of the Medical Record - Do not Copy. 3. On [DATE] at 9:02 a.m., the record for Resident J was reviewed. The record lacked documentation of allegation of abuse for [DATE]. An IDT (Interdisciplinary Team) note dated [DATE] at 6:05 p.m. indicated, but was not limited to, On [DATE] Resident J reported CNA punched her leg to wake her . On [DATE] at 1:28 p.m., the Director of Nursing provided the Risk Management report, dated [DATE] 7:30 a.m. The report indicated but was not limited to, Resident alleges CNA punched her in her right thigh .Immediate action taken .Social services to provide psychosocial support .oriented to person, oriented to place .confused, drowsy, impaired memory, sedated . Each page was stamped with Privileged and Confidential - Not Part of the Medical Record - Do not Copy. 4. On [DATE] at 11:25 a.m., Resident H's record was reviewed. He had [DIAGNOSES REDACTED]. An Admission MDS (Minimum Data Set) dated [DATE] showed Resident H cognition was severely impaired. Resident H was admitted to the facility on [DATE] and expired at the facility on [DATE]. On [DATE] at 10:30 a.m., fall risk assessments were reviewed for Resident H. The documents were labeled they were not part of the permanent record and were for private viewing only. The documents contained interventions after falls that were not available on the Care plans or progress notes. On [DATE] at 3:21 p.m., the Director of Nursing provided the current facility policy, Thinning Guidelines - for Paper Records*, issued [DATE]. The policy failed to provide direction on what the complete medical record should contain. 3XXX,[DATE](a)