STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155348	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35733 Based on interview and record review, the facility failed to ensure a newly admitted resident had immediate orders for wound care for 2 of 3 residents reviewed for wounds. (Resident B, Resident C) Findings include: 1. On 3/6/25 at 9:44 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, displaced intertrochanter fracture of left femur, subsequent encounter for closed fracture with routine healing, other injury of unknown body region, subsequent encounter. An admission Minimum Data Set (MDS) assessment dated [DATE], indicated cognition was intact, 1 stage two pressure ulcer on admit. Resident B admitted to the facility on [DATE], discharged on [DATE]. Care plans included, but were not limited to: Enhanced barrier precautions r/t (related to) impaired skin integrity. Interventions included, but were not limited to: weekly skin checks, Tx (treatment) as ordered, date initiated 1/22/25, revision on 2/28/25. At risk for break in skin integrity. Resident refuses use of Prevalon boot, date initiated 1/21/25, revision on 2/28/25. Interventions included, but were not limited to: Prevalon boots to bilateral feet at all times, date initiated 2/6/25, revision on 2/28/25. Treatment as ordered, date initiated 1/21/25, revision on 2/28/25. Weekly skin checks, date initiated 1/21/25, revision on 2/28/25. Res admitted to facility with 3rd degree burn to right upper arm and non-healing surgical located to coccyx. Resident is at further risk for skin breakdown related to chronic pain, fibromyalgia, recent surgeries, and spondylosis. Resident further is incontinent of bowel and bladder, prefers to stay in bed, and slides down in bed often. Resident refuses use of Prevalon boot, date initiated 1/21/25, revision on 2/28/25. (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions included, but were not limited to: Skin prep bil (bilateral) heels Q (every) shift for prevention, date initiated 1/23/25, revision on 2/28/25 Treatment as ordered, date initiated 1/21/25, revision 2/28/25. Weekly skin checks, date initiated 1/21/25, revision 2/28/25. The resident has potential/actual impairment to skin integrity, date initiated 1/29/25, revision on 2/6/25. Interventions included, but were not limited to: Clean and dry skin after each incontinent episode, date initiated 1/29/25, revision on 2/6/25. A wound observation tool with an effective date of 1/22/25, indicated present on admission 1/21/25. The document included but was not limited to: Observations: Location: right inner ankle Type: pressure Stage: 2 Measurements: Length (cm) 1.0 Width (cm) 1.0 Depth (cm) 0.1 NP(Nurse Practitioner) aware Additional comments: Res admitted to facility with 3rd degree burn to right upper arm and non-healing surgical located to coccyx and stage 2 pressure injury to right inner ankle . A wound observation tool with an effective date of 1/28/25, indicated present on admission 1/21/25. The document included but was not limited to: Observations: Location: right inner ankle Type: pressure Stage: 2 (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measurements: Length (cm) 1.0 Width (cm) 1.0 Depth (cm) 0.8 Additional comments: Res admitted to facility with 3rd degree burn to right upper arm and non-healing surgical located to coccyx and stage 2 pressure injury to right inner ankle. Area is showing improvement, writer suggest resident utilize skin prep to area. Resident continues to be followed per IDT (Interdisciplinary Team) and wound nurse. A wound evaluation and management summary dated 1/30/25, indicated a non-pressure wound of the right ankle full thickness. Etiology: Trauma/injury Wound size (L x W x D) 1 x 0.8 x 0.1 cm Dressing treatment plan: skin prep apply once daily for 30 days Physician orders for January and February 2025 were reviewed and included, but were not limited to: Right inner ankle: apply skin prep to area, every day shift for healing, order date 1/31/25, discontinue date 2/10/25. 2. On 3/7/25 at 11:06 a.m., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, acquired absence of right leg above the knee, atherosclerosis of native arteries of extremities with intermittent claudation, bilateral legs, encounter for orthopedic aftercare following surgical amputation. An admission Minimum Date Set (MDS) assessment dated [DATE], indicated Resident C's cognition was intact, surgical wound on admit. Resident C admitted to the facility on [DATE], discharged on [DATE]. Care plans were reviewed and included, but were not limited to: Has break in skin integrity, date initiated 1/24/25, revision on 2/21/25. Interventions included, but were not limited to: Treatment as ordered, date initiated 1/24/25, revision on 2/21/25. Weekly skin checks. date initiated 1/24/25, revision on 2/21/25. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 1/24/25 at 4:55 p.m., indicated Resident arrived at facility via wheelchair per hospital transport.Resident recently went to ER for eval for cool feeling in leg. Occluded right femoral artery found leading to right above knee amputation 1-16-25. Resident has been receiving betadine and kerlix on stump and stump protector stays on at all times except for skin care. No s/s to wound . (sic) January physician orders were reviewed and included, but were not limited to: [NAME] (sic) entire right above knee amputation wound site with betadine, allow to dry completely, cover with 4 x 4 gauze, wrap with Kerlix, secure with paper tape, change daily every day shift for AKA (above knee amputation), order date 1/26/25, start date 1/27/25. On 3/7/25 at 10:40 a.m., a resident concern and comment form dated 1/28/25 was reviewed for Resident C. The form included but was not limited to Resident C had a concern that his wound dressing had not been changed in the last two days after requests to do so. Follow up indicated according to the DON, the hospital did not send wound dressing orders, orders were received and Resident C was receiving tx's (treatments) . On 3/7/25 at 11:21 a.m., the Director Of Nursing (DON) indicated that during a mandatory staff meeting, it was reviewed it is the nurses responsibility to get orders if the resident admits with a wound and no wound orders. Don't wait on the wound Nurse Practitioner to assess the wound, if admitted on a Friday don't wait to get orders on the next business day. On 3/7/25 at 12:30 p.m., the DON indicated the nurse thought she put in orders for all bony prominences for Resident B, but only orders for heels were put in. The wound physician indicated the right inner ankle wound was non-pressure, it was from trauma, the nurse put it as a pressure wound. On 3/7/25 at 2:20 p.m., LPN 2 indicated wound orders most of the time come on the hospital discharge report, sometimes the hospital nurse gives wound care orders by phone on the resident admission report. LPN 2 indicated if a resident is admitted without wound orders the next step is to contact the facility the resident came from, or call the facility wound nurse if can't reach the physician to at least get wound orders in place until the wound nurse can do the assessment. On 3/7/25 at 2:28 p.m., the RN 3 provided the current treatment orders policy with a revised date of 7/9/24. The policy included, but was not limited to .quality of care is a fundamental principal 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 resident's choices . On 3/7/25 at 2:28 p.m., the RN 3 provided the current skin integrity & pressure ulcer/injury prevention and management policy with a revision date of 7/9/2024. The policy included, but was not limited to, provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurse Society) . This citation relates to Complaint IN00454046. (continued on next page)

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