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	09/26/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to notify the physician and resident representative of changes in a resident's medical status for 1 of 1 residents reviewed for skin conditions and urinary tract infections. The physician was not notified of a new wound, and the resident's representative was not notified of a new wound, new diagnosis, and new medication order. (Resident C) Finding includes: On 9/20/24 at 10:20 A.M., a family member indicated that on 9/18/24 they found a dressing covering a wound on Resident C's foot. Upon further inspection, sores were found on his buttocks, on the back of his thigh, on his scrotum, and on his perineum. They requested a skin assessment be completed that day with the wound nurse to show her Resident C's skin injuries. They indicated they believed that Resident C had a UTI, but lab work had not returned and the resident had not been started on antibiotics yet. In a confidential interview on 9/20/24 at 12:38 P.M., it was indicated that a staff member had put bandages on Resident C's foot without letting anyone know he had sores. It was indicated that the bandages were the wrong type of bandages because when they were pulled away, the sore broke open and the scab was removed. On 9/23/24 at 8:32 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, atopic dermatitis, and urinary tract infection. The most current Quarter Minimum Data Set (MDS) Assessment, dated 6/19/24, indicated Resident C was not assessed for cognitive impairment due to the resident being rarely or never understood, was dependent on staff for bathing, was at risk for pressure injuries, had no skin injuries, required substantial to maximal assistance of staff (staff does more than half) for toileting, and did not have a urinary tract infection (UTI). A skin integrity care plan, dated 5/24/24, indicated staff should provide treatment as ordered and complete weekly skin checks. A pressure injury care plan, dated 9/19/24, indicated Resident C had a pressure injury on his right great toe. Interventions included, but was not limited to, treatment as ordered. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Parkview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 North St Joseph Ave Evansville, IN 47720	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked a care plan for urinary tract infection. Current physician orders included, but was not limited to: Right great toe: Cleanse with wound cleaner and pat dry. Paint Betadine and allow to dry. Cover with foam for protection. Every day shift for protection and as needed for dislodgment, dated 9/20/24. Shearing right back thigh: Cleanse with wound cleaner and pat dry. Apply skin prep to periwound. Apply medical grade honey to shearing and cover with foam. Every day shift every other day for healing and as needed for dislodgment, dated 9/20/24. Left 2nd toe: Paint with Betadine and leave open to air. Every shift, dated 9/20/24. Venelex External Ointment ([NAME]-[NAME] Oil) - Apply to buttocks/scrotum topically every shift for healing and apply to buttocks/scrotum topically as needed for incontinence, dated 9/18/24. Keflex (an antibiotic) 250 mg - Give 1 capsule by mouth three times a day for UTI until 9/25/24, dated 9/19/24. Weekly skin assessments from 8/16/24 to 9/14/24 indicated the following skin impairments were identified: 8/16/24 Weekly - blanchable redness on bilateral buttocks 8/24/24 Weekly - blanchable redness on bilateral buttocks 8/26/24 Update - Nodule on anterior testicle 8/31/24 Update - Nodule on anterior testicle 8/31/24 Weekly - friction/shearing on scrotum 9/7/24 Weekly - friction/shearing on scrotum 9/14/24 Weekly - friction/shearing on scrotum The clinical record lacked documentation to indicate the physician and resident representative had been notified of the skin impairments. Nurse Practitioner (NP) progress notes from 8/19/24 to 9/17/24 did not include documentation to show that identified skin impairments were assessed or treatment was ordered and provided. On 9/17/24 at 10:30 A.M., a psychosocial progress note indicated family were informed that a urinalysis was done on 9/16/24 but had not yet resulted. Lab results, collected on 9/16/24 and resulted on 9/18/24, indicated Resident C had proteus mirabilis bacteria in his urine indicating a UTI. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation to indicate the resident's representative had been informed of the urinalysis results or the new antibiotic medication order. A care management progress note, dated 9/18/24 at 4:17 P.M., indicated a head to toe skin assessment had been completed with the family at the bedside. Upon assessment the resident was noted to have an open area to right great toe, shearing to posterior right thigh, and skin loss to buttocks and scrotum. A wound observation tool progress note, dated 9/19/24, identified the open area to the right great toe was a stage 2 pressure ulcer measuring 0.4 centimeters (cm) in length, 0.3 cm in width, and 0.2 cm in depth. On 9/24/24 9:16 A.M., the Director of Nursing (DON) indicated documentation of notification to the physician and family would be found in the progress notes and was not documented anywhere else in the clinical record. On 9/25/24 at 9:30 A.M., the Director of Nursing (DON) indicated staff should have notified the physician and family of the nodule, shearing, and friction on Resident C's scrotum when it was identified. She indicated that the nurse who applied the dressing to Resident C's toe did not feel it was a concern and did not notify the physician or family. She indicated family should be notified if a resident received a new diagnosis or new medication order. On 9/26/24 at 9:51 A.M., the Administrator provided a current Changes in Resident's Condition or Status policy, dated 11/26/2018, that indicated Communicate the change in resident's status to the appropriate practitioner. Notify the resident's family about the change in the resident's status and the subsequent treatment plan . Document the procedure . Documentation associated with identifying and communication a change in a resident's status includes: communication with other health care team members . communication with resident's family. On 9/26/24 at 9:51 A.M., the Administrator provided a current Nursing Documentation policy, dated 8/20/2019, that indicated Nursing notes will reflect any significant nursing observations of the resident. On 9/26/24 at 10:31 A.M., the DON provided a current Area of Focus: Basic Skin Management policy, dated 11/29/2023, that indicated If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document the assessment/observation, obtain treatment orders, and notify MD (medical doctor) and responsible party. This citation related to complaint IN00443638. 3.1-5(a)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48147 Based on interview and record review, the facility failed to develop care plans for 2 of 3 residents reviewed for Urinary Tract Infections (UTI), 1 of 1 residents reviewed for tube feedings, 2 of 5 residents reviewed for unnecessary medications, and 1 of 1 residents reviewed for hospice services. A care plan was not developed for residents receiving high risk medications, timeliness of tube feedings, for residents requiring assistance with transferring, and after residents received a new diagnosis and new medication orders. (Resident C, Resident N, Resident L, Resident Z, Resident J, Resident V) Findings include: 1. On 9/23/24 at 8:32 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, Urinary Tract Infection. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/19/24, indicated Resident C was not assessed for cognitive impairment due to rarely or never being understood, required substantial to maximal assistance of staff (staff does more than half) for toileting, was always incontinent of bowel and bladder, and did not have a UTI. Current physician orders included, but were not limited to: Keflex (an antibiotic) 250 milligrams (mg) - Give one capsule by mouth three times a day for UTI, dated 9/19/24 with an end date of 9/25/24 The clinical record lacked a care plan related to the resident's urinary tract infection or antibiotic use. On 9/25/24 at 9:30 A.M., the Director of Nursing (DON) indicated that Resident C should have a care plan for a urinary tract infection and antibiotic use, but did not have one. 2. On 9/23/24 at 2:11 P.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, edema and hypertension. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/28/24, indicated Resident N was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for toileting, and received a diuretic during the 7-day lookback period. Current physician orders included, but were not limited to: Furosemide (a diuretic) 40 milligrams (mg) - Give 40 mg by mouth one time a day for edema, dated 5/21/24. Spironolactone (a diuretic) 25 mg - Give 25 mg by mouth one time a day for edema, dated 5/21/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked a care plan related to the resident's edema, diuretic use, or potential side effects of the diuretic. On 9/25/24 at 12:56 P.M., the Director of Nursing (DON) indicated the facility did not initiate care plans for diuretic use or monitor for side effects of diuretics. 50827 3. On 9/23/24 at 12:20 P.M. Resident L's clinical record was reviewed and indicated the resident had diagnoses that included but was not limited to atrial fibrillation, benign prostatic hypertrophy, and diabetes mellitus. An MDS (Minimum Data Set) Assessment that was completed upon admission, 8/23/24, indicated that the resident was cognitively intact, used a walker and a wheelchair, required partial to moderate assistance with transfers and toileting. The clinical record also indicated that Resident L was being treated for a treatment resistent urinary tract infection caused by proteus mirabilis. Physician orders for Resident L included but were not limited to: Invanz (antibiotic) injection 1 gram, intramuscularly one time a day for 5 days dated 9/20/24. A current care plan, dated 8/23/24, in Resident L's chart indicated that the resident required ADL (activities of daily living) assistance and mobility as needed. Resident L's clinical record lacked a care plan related to their level of mobility and assistance required. The resident's clinical record also lacked a care plan to address their urinary tract infection and antibiotic use. 4. On 9/24/24 at 12:15 P.M. Resident Z's clinical record was reviewed and indicated the resident had diagnoses that included but were not limited to cerebral vascular accident (stroke), coronary artery disease, and peripheral vascular disease. An admission MDS dated [DATE] indicated that the resident was cognitively intact, used a walker and/or wheelchair, required partial or moderate assistance with transfers and toileting, and the resident was taking antiplatelet medications. Physician orders included but were not limited to: Aspirin (an antiplatelet medication) 81 milligrams by mouth once a day, dated 9/17/24. Ativan (an antianxiety medication) 0.5 milligrams by mouth twice a day, dated 9/8/24. Resident Z's clinical record lacked a care plan related to an antiplatelet medication and an antianxiety medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 9/25/24 at 2:09 P.M. Resident J's clinical record was reviewed and indicated that resident had diagnoses that included but was not limited to heart failure and atrial fibrillation. A significant change MDS dated [DATE] indicated that the resident was cognitively intact and receiving hospice care. Physician Orders included but were not limited to: Bumex (a diuretic medication) 1 milligram once daily, dated 6/13/24. Resident J's clinical record lacked a care plan related to diuretic use. An interview with the DON (Director of Nursing) on 9/25/24 at 10:50 A.M. indicated that it was expected for a resident to have a care plan specifically for an antibiotic, a psychotropic medication such as ativan, but they would not have expected a care plan for 81 milligram aspirin. 6. During an interview and observation on 9/19/24 at 2:26 P.M., Resident V indicated staff are often late administering her enteral feeding. The enteral feed machine was turned off and no nutritional supplement or water was being delivered at this time. Resident V indicated she was unsure if she had lost weight; the facility had never weighed her because she felt like she couldn't breathe well while being in a mechanical lift. On 9/23/24 at 8:20 A.M., Resident V's clinical record was reviewed. Resident V was admitted on [DATE]. Diagnoses included, but were not limited to, spinal muscular atrophy and scoliosis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/17/24, indicated Resident was cognitively intact, was completely dependant on staff (staff does all of the effort) for bathing, toileting, and mobility, and was receiving nutrition through tube feeding. Current physician orders included, but were not limited to: NPO (nothing by mouth) diet, NPO texture. Start date: 5/7/24 Change tubing and bag set for enteral feeding every 24 hours, everyday on day shift when turning pump on at 1300 (1:00 P.M.). Start date: 6/5/24 Vital AF 1.2cal (nutritional supplement) at 63 milliliters (mL) per hour for 15 hours via pump. Flush with 45 milliliters free water every hour. Turn pump off at 0400 (4:00 A.M.) and resume pump at 1300 (1 P.M.). Goal rate to be 63mL/hour as tolerated. Monitor for refeeding syndrome. Two times a day. Start date: 9/10/24 Current care plans included, but were not limited to: The resident has nutritional problem or potential nutritional problem related to NPO (nothing by mouth) with feeding tube for sole source of nutrition and hydration. Resident is allowed to have ice chips. Date Initiated: 5/16/24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident is totally dependent on one staff for eating via gastrostomy tube. Date Initiated: 9/17/24 The clinical record, including progress notes and order administration, lacked resident refusal or explanation for nutritional supplement to not being administered on 9/19/24. An admission progress note, dated 4/26/24, indicated Resident V weighed 85 pounds (height 56 inches). A weight recorded on 5/5/24, indicated Resident V weighed 70.2 pounds, a body mass index (BMI) of 15.7 (underweight). There was no alternative process to determine weight or body mass index for the resident. During an interview on 9/26/24 at 10:30 A.M., the DON (director of nursing) indicated Resident V had only been weighed on admission due to refusal of being weighed. On 9/26/24 at 10:45 A.M., the Administrator provided a policy titled Enteral Nutritional Therapy, revised 9/10/24, that indicated The facility will provide continuous enteral nutritional therapy in accordance with physician orders and professional standards of practice. Based on a resident's comprehensive assessment, the facility must ensure that a resident who is fed by enteral means receives the appropriate treatment and services. On 9/26/24 at 9:51 A.M., the Administrator provided a current Resident Assessment Instrument and Care Plan Development policy, revised 8/16/22, that indicated .develop an individualized person-centered care plan for each patient that includes the patient's voice, the patient's goals while residing in the facility and for discharge that assist the patient to attain and/or maintain their highest practicable level of well-being . other sources of information are to be included when developing an individualized person-centered care plan for each patient that is reviewed by the interdisciplinary team . On 9/26/24 at 9:51 A.M., the Administrator provided a current Changes in Resident's Condition or Status policy, dated 11/26/18, that indicated The care plan should address the resident's risk factors, allow for rapid identification of a change in status, and define baseline assessment findings. This citation related to complaint IN00443638. 3.1-35(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview, observation, and record review, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADLs) were bathed or assisted to bathe for 5 of 7 residents reviewed for ADL care. (Resident V, Resident P, Resident S, Resident T, Resident C) Findings include: 1. On 9/23/24 at 8:20 A.M., Resident V's clinical record was reviewed. Resident V was admitted on [DATE]. Diagnoses included, but were not limited to, spinal muscular atrophy and scoliosis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/17/24, indicated Resident was cognitively intact and was completely dependant on staff (staff does all of the effort) for bathing, toileting, and mobility. Current care plans included, but were not limited to: Resident request a Complete Bed Bath one time a week and often refuses. Date Initiated: 4/27/24 During an interview on 9/24/24 at 2:40 P.M., Resident V indicated she would like to receive a complete bed bath more than once a week, but staff told her that is all they have time to provide a complete bed bath. On 9/26/24 at 8:45 A.M., the DON (Director of Nursing) provided Resident V's complete bed bath record from 8/1/24 to 9/26/24. A review of Resident V's documented showers indicated the resident did not receive a complete bath or shower during the following dates: 8/6, 7, 8, 9, 11 8/13, 14, 15, 16, 17, 18, 19 ,20, 21, 22, 23, 24 8/26, 27, 28, 29, 30, 31 9/2, 3, 4, 5, 6, 7, 8 9/10, 11, 12, 13, 14, 15 9/17, 18, 19, 20, 21, 22 There was no documentation of resident refusals. 50827 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 9/23/24 at 10:30 A.M. Resident P's clinical record was reviewed and indicated the resident had diagnoses that included but was not limited to diabetes mellitus and COPD (chronic obstructive pulmonary disease). A Quarterly MDS (Minimum Data Set) Assessment on 6/20/24 indicated Resident was cognitively intact, had no behaviors, and used a wheelchair. A state optional MDS dated [DATE], indicated Resident was independent in bed mobility and toileting, required supervision with transfers, and the resident was on a pain medication regimen with occasional pain that affected day to day activities. On 9/20/24 at 11:36 A.M. Resident P indicated they had not been getting showers on time, staff had a hard time finding her to give her showers even though she told them where she would be. On 9/23/24 at 10:17 A.M. a sign was observed on Resident P's closet door that indicated the resident is to have showers on day shift, on Tuesday and Thursdays. Resident P had a current care plan that indicated they have a self-care performance deficit, required physical assistance with one staff member for bathing and showering, and preferred to have a shower during the day twice a week. During clinical record review on 9/23/24 at 10:45 A.M., Resident P's clinical record had documentation of 3 showers in the last 30 days. Documented showers were dated 9/6/24, 9/13/24, and 9/20/24. All given on Friday. The clinical record lacked any documented showers or refusals of showers by the resident on the following days: 9/3/24, 9/5/24, 9/10/24, 9/12/24, 9/17/24, 9/19/24. 46758 3. During an interview on 9/20/24 at 9:21 A.M., Resident S indicated not getting bed baths on the days scheduled. On 9/24/24 at 9:32 A.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), muscle weakness, and morbid obesity. On 9/16/24 at 10:30 A.M., Resident S was observed laying in bed with a clean gown and linen, hair was clean, face was somewhat stubbly. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident S was cognitively intact. The resident needed substantial assistance with hygiene, dressing, and transferring. Current physician orders included but were not limited to: Bilateral enablers to bed to aid in repositioning, ADL (Activities of Daily Living) functioning, and bed mobility. Side rail is not considered a restraint dated 9/23/24. Keep head of bed elevated d/t (Due To) shortness of breath while lying flat r/t (Related To) diagnosis of COPD every shift related dated 9/18/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current ADL care plan revised on 1/29/24 indicated the resident has a self-care deficit related to The resident has an ADL self-care performance deficit r/t morbid obesity and dyspnea with exertion. Interventions included, but were not limited to, prefers bed bath instead of a shower 2 to 3 times/week revised on 1/29/24 and praise all efforts of self-care initiated on 5/22/23. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering and bathing indicated the Resident received bed baths Monday, Thursday and Saturday. A record review from 4/1/24 through 9/26/24 indicated Resident S lacked documented bed baths or refusals on the following Monday April 15 Thursday May 24 Monday June 3 Monday June 10 Monday August 19 Monday August 29 During an interview on 9/20/24 at 9:21 A.M., Resident S indicated not getting bed baths on the days scheduled. 48147 4. On 9/19/24 at 1:14 P.M., Resident T indicated she didn't feel clean all the time and wanted her hair washed more frequently. The last time she had her hair washed was more than a week ago. She indicated that staff did not usually wash her hair if she received a bed bath. At that time, her hair was observed to be oily. On 9/23/24 at 1:50 P.M., Resident T's clinical record was reviewed. Resident T was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and generalized muscle weakness. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/31/24, indicated Resident T was mildly cognitively impaired, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care. An Activities of Daily Living (ADL) Assistance care plan, dated 5/16/24, indicated staff was to assist with mobility and ADLs as needed. A current shower schedule indicated Resident T was scheduled to receive showers on Mondays and Thursdays during the day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 2:01 P.M., the Administrator provided bathing performed from 5/20/24 to 9/23/24. Resident T did not receive a shower or bed bath with a hair wash on: 5/23/24 5/27/24 5/30/24 6/3/24 6/6/24 6/13/24 6/17/24 6/20/24 6/24/24 6/27/24 7/18/24 7/22/24 7/25/24 7/29/24 8/1/24 8/5/24 8/12/24 8/15/24 8/19/24 8/22/24 8/26/24 8/29/24 9/2/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/5/24

9/9/24

9/12/24

9/16/24

9/19/24

On 9/23/24 at 1:25 P.M., Licensed Practical Nurse (LPN) 7 indicated Resident T did not get showers because she was difficult to get up.

5. In a confidential interview on 9/19/24 at 9:48 P.M., it was indicated that Resident C preferred to have a shower twice a week due to eczema, but the facility wanted to compromise and give the resident one shower and one bed bath every week and sometimes the resident got two bed baths instead of a shower during the week. They also indicated that the resident did not like facial hair and preferred to be clean shaven.

On 9/23/24 at 10:12 A.M., Resident C was observed in bed with his eyes closed. He had hair stubble on his chin and upper lip.

On 9/24/24 at 8:31 A.M., Resident C was observed in the restorative dining room. He had hair stubble on his chin and upper lip.

On 9/23/24 at 8:32 A.M., Resident C's clinical record was reviewed. Resident C was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, and atopic dermatitis.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/19/24, indicated Resident C was not assessed for cognitive ability due to being rarely or never understood, was dependent on staff for bathing, and had no rejection of care.

An Activities of Daily Living (ADL) Assistance care plan, dated 5/24/24, indicated staff was to assist with mobility and ADLs as needed.

An ADL self care performance deficit care plan, dated 6/12/24, indicated the resident was to be shaved daily in the morning.

Current physician orders included, but were not limited to:

Ensure resident is shaved daily every day shift, dated 9/18/24.

A current shower schedule indicated Resident C was scheduled to receive showers on Tuesdays during the day and a complete bed bath on Saturdays during the day.

(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 2:01 P.M., the Administrator provided bathing performed from 5/24/24 to 9/23/24. Resident C did not receive a shower on the following Tuesdays: 5/28/24 6/4/24 6/11/24 6/18/24 7/23/24 8/13/24 8/27/24 9/3/24 9/10/24 9/17/24 Resident C did not receive a bed bath on the following Saturdays: 7/13/24 8/10/24 On 9/24/24 at 2:42 P.M., Certified Nurse Aide (CNA) 10 indicated that residents got showers twice a week, and if they preferred a shower, they would be given a shower. On 9/26/24 at 10:53 A.M., the Director of Nursing (DON) indicated that staff filled out shower sheets, but they were not a part of the clinical record. All showers should be documented in Point of Care (POC) Tasks (a documentation program for CNAs). On 9/26/24 at 10:31 A.M., the Administrator provided an Activities of Daily Living (ADLs) policy, revised 2/12/24, that indicated A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This citation related to complaint IN00443638 and complaint IN00440635. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-38(b)(2) 3.1-38(b)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview, record review, and observation, the facility failed to ensure residents with limited range of motion received restorative nursing services to further prevent decrease in range of motion for 2 of 4 residents reviewed for ADL (activities of daily living) care who receive restorative nursing. (Resident V, Resident 35) Findings include: 1. During an interview on 9/19/24 at 2:14 Resident V indicated she had not received restorative nursing any days that week. Resident V had contractures of all extremities. On 9/23/24 at 8:20 A.M., Resident V's clinical record was reviewed. Resident V was admitted on [DATE]. Diagnoses included, but were not limited to, spinal muscular atrophy and scoliosis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/17/24, indicated Resident was cognitively intact and was completely dependant on staff (staff does all of the effort) for bathing, toileting, and mobility. Current care plans included, but were not limited to: Resident has impaired mobility due to the diagnosis of spinal muscular atrophy and is on a restorative passive ROM (range of motion) program. Date Initiated: 7/4/24 Resident will tolerate 2 sets of 20 reps of gentle stretching to bilateral upper extremities through target date. Date Initiated: 7/4/24 Assist resident in performing bilateral lower passive ROM. 10-15 reps. Stop activity if resident complains of pain. Date Initiated: 8/24/24 Assist resident in performing upper extremity passive ROM. 10-15 reps. Stop activity if resident complains of pain. Date Initiated: 8/24/24 On 9/24/24 at 1:40 P.M., the Administrator provided documents titled Restorative Program for Resident V: 9/13/24 blank 9/14/24 documented not applicable 9/15/24 documented not applicable and resident refused 9/16/24 documented not applicable 9/17/24 documented 10 minutes completed and marked resident refused (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/18/24 documented 5 minutes completed and marked resident refused 9/19/24 documented 5 minutes completed and marked resident refused 9/20/24 documented not applicable 9/21/24 documented resident refused 9/22/24 documented resident refused The clinical record, including progress notes and administration records, lacked further documentation relating to days restorative nursing was not provided to Resident V. 2. On 9/23/24 at 10:49 A.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on [DATE]. Diagnoses included, but were not limited to, muscle weakness and dementia. The most recent Quarterly MDS Assessment, dated 6/17/24, indicated Resident 35 was cognitively intact and required partial assistance from staff for bathing, toileting, and transfers. Current care plans included, but were not limited to: Resident has impaired mobility due to the diagnosis of dementia and muscle weakness. Resident is on a restorative program. Date Initiated: 7/9/24 Provide Active range of motion to bilateral upper extremities using #1 free weights or cycle on level 1 or 0 for 15 to 20 minutes. Stop Activity if resident complains of pain. Revision on: 9/5/24 On 9/24/24 at 1:40 P.M., the Administrator provided documents titled Restorative Program for Resident 35. The following days included active range of motion marked not available or was left undocumented/blank: 9/13/24 9/18/24 9/19/24 9/21/24 9/22/24 9/23/24 The clinical record, including progress notes and administration records, lacked further documentation relating to days restorative nursing was not provided to Resident 35. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 8:53 A.M., the Administrator indicated that every resident care planned for restorative nursing services should be receiving restorative nursing services seven days a week unless the care plan specifies only certain days. On 9/26/24 at 10:45 A.M., the Administrator provided a policy titled Restorative Nursing, dated 11/20/23, that indicated Measurable objectives and interventions must be documented in the care plan and in the medical record. The trained CNA will document provided techniques per the restorative care plan in the medical record. The licensed nurse will conduct an evaluation on a routine basis, to include the progress towards goal and response to the program. 3.1-42(a)(1)

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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. 50827 Based on observation, record review, and interview the facility failed to ensure an oxygen concentrator filter was being cleaned for 1 of 1 resident reviewed for respiratory care (Resident P). Finding includes: On 9/23/24 at 10:17 A.M., Resident P's oxygen concentrator was observed to have moderate dust on the filter cover. On 9/23/24 at 10:30 A.M. Resident P's clinical record was reviewed and indicated the resident had diagnoses that included but was not limited to COPD (chronic obstructive pulmonary disease). A Quarterly MDS (Minimum Data Set) Assessment on 9/23/24 indicated Resident was cognitively intact and required the use of oxygen. Resident P had a current physician order for oxygen at three liters, continuously per nasal cannula, dated 5/4/24. On 9/25/24 at 10:41 A.M. DON (Director of Nursing) indicated that nurses were responsible for cleaning filters on oxygen concentrators every Sunday and it was expected to be a task in a resident's Treatment Administration Record. Resident P's clinical record lacked an order for the Treatment Administration Record to clean the filter for their oxygen concentrator. On 9/25/24 at 02:00 P.M., Resident P's oxygen concentrator observed to still have moderate dust on filter cover. A policy for oxygen administration provided by the Administrator on 9/26/24 at 11:30 A.M. indicated external filters should be checked daily and all dust should be removed. Filters should be washed with soap and water, then dried and reinserted once weekly and as needed. 3.1-47(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48147 Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 5 of 6 days during the annual survey period. Finding includes: During an observation on 9/23/24 at 2:59 P.M., a posted nurse staffing data sheet, dated 9/23/24, was observed on the nurses station desk inside the main entrance. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), QMA (Qualified Medication Aide) and RN (Registered Nurse). The sheet indicated that 2 LPNs worked 20 hours between 7:00 A.M. and 7:00 P.M. but did not specify the actual hours that the staff worked. The sheet indicated that 1 QMA worked 8 hours between 7:00 A.M. and 7:00 P.M. but did not specify the actual hours that the staff worked. The sheet indicated that 1 QMA worked 4 hours between 7:00 P.M. and 7:00 A.M. but did not specify the actual hours that the staff worked. During an observation on 9/24/24 at 8:37 A.M., a posted nurse staffing data sheet, dated 9/24/24, was observed on the nurses station desk inside the main entrance. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for CNA, LPN, QMA, and RN. The sheet indicated that 2 QMAs worked 20 hours between 7:00 A.M. and 7:00 P.M. but did not specify the actual hours that the staff worked. The sheet indicated that 14 CNAs worked 60 hours between 3:00 P.M. and 11:00 P.M. but did not specify the actual hours that the staff worked. On 9/25/24 at 9:30 A.M., the Administrator provided a copy of posted nurse staffing sheets for dates 9/19/24, 9/20/24, 9/23/24, 9/24/24, and 9/25/24. Each of these dates did not reflect actual hours worked. On 9/25/24 at 10:15 A.M., the Director of Nursing indicated she was unable to tell by looking at the posted nurse staffing sheet which hours staff worked during shifts where hours worked did not equal the specified shift length. On 9/26/24 at 9:09 A.M., the Administrator provided a Posted Nurse Staffing Data and Retention Requirements policy, revised 7/2023, that indicated The facility must post the following information at the beginning of each shift . total number and actual hours worked by the following categories of licensed and unlicensed nursing staff .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to ensure proper storage of medications for 4 of 6 medication carts. Loose pills were observed in the medication cart drawers. (Cherry Lane Medication Cart, Dogwood Lane Cart 1, [NAME] Lane Cart 1, [NAME] Lane Cart 2) Findings include: On 9/19/24 at 9:00 A.M., the Cherry Lane Medication Cart was observed with the following loose pills and materials: 1 small, oblong, white, pill Broken pieces of peach pill 1 small, round, white, pill 1 bottle of water in lower drawer On 9/19/24 at 9:05 A.M., the Dog [NAME] 1 Medication Cart was observed with the following loose pills: 1 small round pink pill with # 50 1 white capsule with #IP 101 1 long, oblong, white pill TGL #341 1/2 small, round, white pill 1 small, round, white pills 1/2 small, oblong, pink pill On 9/19/24 at 9:18 A.M., the [NAME] Lane 1 Medication Cart was observed with the following loose pills: 2 1/2 small, round, white pills 1/2 small, round, brown pill On 9/19/24 at 9:25 A.M., the [NAME] Lane 2 Medication Care was observed with the following loose pills: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 small, round, red pill 1/2 small, oblong, white pill 1 small, round, pink pill During an interview on 9/19/24 at 9:12 A.M., RN (Registered Nurse) 3 indicated water in bottom should not be there. During an interview on 9/19/24 at 9:15 A.M., RN (Registered Nurse) 5 indicated that there should be no loose pills in the carts and that if there were the pills are placed in drug buster. On 9/26/24 at 10:40 A.M., the Administrator provided a current policy Storage and Expirations Dating of Medication, Biologicals revised 8/7/23. The policy indicated .the facility should ensure that all medications . are securely locked in a cabinet/cart that is inaccessible by residents and visitors. 3.1-25(j)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50827 Based on record review and interview, the facility failed to ensure the documentation was completed and accurate for 2 of 2 residents reviewed for accuracy of falls documentation. (Resident P and Resident 12) Findings include: 1. On 9/23/24 at 10:30 A.M. Resident P's clinical record was reviewed and indicated the resident had diagnoses that included but was not limited to diabetes mellitus and COPD (chronic obstructive pulmonary disease). A Quarterly MDS (Minimum Data Set) Assessment on 9/23/24 indicated Resident was cognitively intact, had no behaviors, and used a wheelchair. A state optional MDS dated [DATE], indicated Resident was independent in bed mobility and toileting, required supervision with transfers, and the resident was on a pain medication regimen with occasional pain that affected day to day activities. A progress note in Resident P's clinical record, dated 9/18/24 at 3:54 A.M., indicated the resident was found laying on the floor, face down, in her room. Indicated that it was believed Resident P rolled out of bed. Resident was found by CNA doing routine checks. Did not have any complaints of pain at that time. The progress note also indicated that the resident sleeps on the edge of their bed, and no injury was noted. A fall risk assessment dated [DATE] was completed for Resident P. A neurological check list was started on 9/18/24 at 2:15 A.M. Within the neurological check list, the 1st, 4 hour check time slot on 9/18/24 at 5 P.M. was skipped (blank) and indicated the resident was sleeping. The 4th, 8 hour time slot with no date added, was blank with no documentation for reason. The 24 hour after last 8 hour, check with no added date, was blank with no documentation for reason. The clinical record lacked a completed neurological assessment after Resident P's fall on 9/18/24. An interview with the DON (Director of Nursing) on 9/25/24 at 11:37 A.M. indicated there should be a risk assessment and neurological check list completed after each fall event. Indicated that neurological check lists should have been completed fully, regardless if a resident were sleeping during the neurological check. 46758 2. On 9/09/23/24 at 6:29 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, dementia disorder, schizoaffective disorder, muscle weakness, and intellectual disabilities. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated that Resident 12 was severely cognitively impaired. Resident 12 needs partial help for transferring, dressing, and hygiene. Current physician orders included, but were not limited to: Up in wheelchair with ant-tippers and anti-rollback dated 8/31/24 Scoop mattress to define bed perimeter dated 8/6/24 Bed against the wall dated 8/6/24 The current falls care plan indicates that the resident is a fall risk due to impaired mobility with and will not sustain serious injury requiring hospitalization through the next review date. Interventions included but not limited to, 2 staff members for toileting, initiated 08/22/2024, anti-tippers to wheelchair initiated 8/28/2024, and anti-rollback initiated 8/28/24. On 9/25/26 at 10:00 A.M., the DON (Director of Nursing) provided copies of Neurological Check List for Resident 12 as follow: Fall #1 7/20/24 at 8:30 P.M. lacked first 15-minute vital signs 7/20/24 at 8:45 P.M. lacked second 15-minute vital signs 7/20/24 at 9:30 P.M., lacked first 30-minute vital signs 7/20/24 at 10:00 P.M. lacked second 30-minute vital signs 7/20/24 at 10:30 P.M. lacked third 30-minute no vital signs and neuro checks 7/20/24 at 11:00 P.M. lacked fourth 40 minute no vital signs and neuro check time slot marked skipped (blank) reason sleeping 7/21/24 at 1:00 A.M. lacked first 2-hour vital signs and neuro checks time slot was marked skipped (blank) reason sleeping 7/21/24 at 3:00 A.M. lacked second vital signs 7/21/24 at 11:00 A.M. lacked first 4-hour vital signs no vital signs 7/21/24 at 3:00 P.M. lacked second 4-hour vital signs 7/21/21 7:00 no vital signs for 3rd 4 hours 7/22/24 at 7:00 A.M. new fall so the neuro checks are started at beginning of that fall (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall #4 8/21/24 12:00 new fall and neuro assessment started again 8/21/24 at 2:45 P.M. lacked fourth 15-minute vital sign check resident was listed as combative but was still able to the neuro check 8/21/24 at 10:45 P.M. lacked fourth 2-hour vital signs resident was combative and refused- this was documented in the nurses notes also Fall #5 8/22/24 at 6:4. resident fell again restarted neuro assessment 8/22/24 at 7:15 A.M. lacked second 15-minute vital signs time slot skipped (blank) indicated resident refused 8/22/24 at 3:30 P.M. lacked third 2-hour vital signs and neuro checks not done because resident was listed as sleeping 8/23/24 at 9:30 A.M. lacked fourth 4-hour vital signs and neuro check reason missed indicated was on a second form there was no other form on a second neuro form 8/24/24 at 1:30 A.M. lacked first 8-hour vital signs and neuro assessments missing because indicated resident was sleeping Fall #6 8/28/24 at 7:15 A.M. started new assessment 8/31/24 at 6:00 PM lacked 24 hours after last 8 hour not completed vital signs or neuro assessment new fall Fall #7 8/31/24 11:50 AM restart neuro assessment During an interview on 9/25/24 at 10:30 A.M., the DON (Director of Nursing) indicated that all of the boxes should be completed on the Neurological Check List. On 9/26/24 at 9:50 A.M., the DON provided a current Fall Management policy reviewed on 9/22/2023. The policy indicated . the facility will assess the resident .with any fall event .documentation will include .vitals signs . 3.1-50(a)(1) 3.1-50(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 Based on interview and record review, the facility failed to ensure a communication process with hospice personnel was developed and implemented, including how the communication will be documented between the LTC (long term care) facility and the hospice provider, and to ensure that the needs of the resident were addressed. The clinical record lacked documentation of ongoing communication between facility staff and hospice staff for 1 of 1 residents reviewed for hospice. (Resident J) Finding includes: On 9/25/24 at 2:09 P.M. Resident J's clinical record was reviewed and indicated that Resident had diagnoses that included but was not limited to heart failure and atrial fibrillation. A significant change MDS (Minimum Data Set) assessment dated [DATE] indicated that the resident was cognitively intact and receiving hospice care. Physician Orders included but were not limited to: Admit to (Name of Hospice Company), dated 6/15/24. Resident J's clinical record lacked a care plan related to hospice services. Resident J's clinical record lacked any documentation of communication between hospice staff and facility staff. There was no hospice medical record within Resident's clinical record. On 9/25/24 at 2:27 P.M. LPN (Licensed Practical Nurse) 11 indicated that (Name of Hospice Company) did not utilize physical hospice binders any longer, an online portal was utilized. On 9/26/24 at 9:41 A.M. LPN 9 indicated that they believed the DON (Director of Nursing) is the one who had access to the hospice portal for Resident J. On 9/26/24 at 9:55 A.M. the DON indicated that unit managers and the infection prevention nurse have her username and password to log into the portal for hospice. Also indicated that the hospice staff was very good at communicating with their nurses during the visits, nurses had to sign tablet of hospice staff during visit. All hospice progress notes, vitals, and visit notes were only accessible through the hospice portal. QMA (Qualified Medication Aide) 8 indicated, on 9/26/24 at 10:06 A.M., they were not aware that (Name of Hospice Company) had switched to an online portal. At 10:07 A.M. on 9/26/24, LPN 9 indicated that if the DON was not present in the facility when they needed to access Resident J's hospice records, they would text her to get the log in information or call hospice directly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Parkview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 North St Joseph Ave Evansville, IN 47720	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator provided a hospice policy on 9/25/24 at 10:00 A.M. The policy indicated that the facility provides hospice care under a written agreement and must ensure that each residents' plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy indicated a Communication Protocol: Prior to the admission of any Facility resident to Hospice, Hospice and Facility shall work together to develop a written communication protocol governing how they will communicate all information needed for the Hospice Patients' care (such as physician orders and medication information), including how such communication will be documented to ensure that the needs of Hospice Patients are addressed and met twenty-four (24) hours a day. The communication protocol shall include, among other things, a procedure that clearly outline the chair of communication between the parties in the event a crises of emergency develops, a change of condition occurs, and/or changes to the Hospice Plan of Care are indicated, and it must also address how Hospice Physician orders will be communicated to Facility staff. Such protocol shall be distributed to all Hospice and Facility staff involved in the Hospice Patients' care. 3.1-13(m)