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	12/11/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview, the facility failed to ensure the kitchen manager met required qualifications for 1 of 1 dietary manager qualifications reviewed. 80 of 82 residents in the facility received nutrition provided by facility dietary.Finding includes: During an interview on 12/8/25 8:45 A.M., the dietary manager indicated she did not have a dietary manager certification. On 12/11/25 at 8:25 A.M., the dietary manager's employee file was reviewed; the employee file indicated the dietary manager had been employed since 10/15/14 and had enrolled to take the dietary manager training 8/20/24, but had not yet taken it. During an interview on 12/8/25 at 8:45 A.M., the dietary manager indicated the dietician worked through a contract and was only not in the facility full time. On 12/11/25 at 1:50 P.M., the Administrator provided a policy titled Departmental Leadership Requirements, revised 4/16/24, that indicated If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services food service managers or dietary managers meets State requirements for food service managers or dietary managers. 3.1-20(e)

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared to meet the individual needs of residents receiving puree diet for 1 of 3 observation of puree foods. Finding includes: During an interview on 12/10/25 at 11:02 A.M., the dietary manager indicated there were four residents who received puree diet, and one resident received double puree portions. During an observation on 12/10/25 at 11:04 A.M., dietary staff prepared puree zucchini, puree noodles, and puree beef. The beef was not of puree consistency and was dry, thick, with lumps. During an interview on 12/10/25 at 11:14 A.M., the dietary manager indicated puree consistency should be similar to applesauce. During an observation on 12/10/25 at 11:50 A.M., dietary was checking the temperature of the foods served on the steam table. The dietary manager indicated the puree beef was not the appropriate consistency; she added two cups of beef broth to the puree beef and placed in back in the serving dish. The beef was not of puree consistency and was thick with lumps. On 12/11/25 at 1:53 P.M., the Regional Nurse provided a document titled Diet Orders that indicated only two residents in the facility received puree altered foods. On 12/11/25 at 1:10 P.M., the Administrator provided a policy titled Puree Diet, revised 3/15/22, that indicated This diet consists of foods that are easy to swallow because they are blended, whipped, or mashed until they are a pudding-like texture. All foods on this diet should be smooth and free of lumps. 1.3-21(a)(3)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure that residents who were self-administering medications were assessed for capability to self-administer medications for 1 of 1 residents with medications observed in their room. (Resident 2)Finding includes:On 12/9/25 at 9:31 A.M., Resident 2 was observed in bed with a bottle of Nystatin, dated 1/2/25, on her bedside table. At that time, Resident 2 indicated that she used the Nystatin as needed to treat thrush (a yeast infection) in her mouth. On 12/9/25 at 11:22 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, schizophrenia, and diabetes mellitus. The most current Annual Minimum Data Set (MDS) Assessment, dated 11/20/25, indicated that Resident 2 had mild cognitive impairment, was independent in eating and transferring, required setup assistance of staff for toileting and bathing, and did not have any infections.Discontinued physician orders included, but were not limited to:Nystatin Mouth/Throat Suspension (a medication used to treat fungal infections) 100,000 units per milliliter (mL) - Give five milliliters by mouth four times a day for thrush for 14 Days. May keep at bedside, dated 1/3/25 and completed 1/17/25.The clinical record lacked a current order for Nystatin.The clinical record lacked documentation that Resident 2 had an active diagnosis of thrush.A care conference was completed on 10/14/25 with the resident and the resident's family member in attendance.The clinical record lacked a care plan for the self-administration of Nystatin.The clinical record lacked a self-administration of medication evaluation for Nystatin.During an interview on 12/10/25 at 11:37 A.M., the Director of Nursing (DON) indicated that there was not a self-administration of medication evaluation for the Nystatin, and the medication was from an old order, but the resident would not let the staff remove it from her room.On 12/11/25 at 12:50 P.M., the Administrator provided a current Self-Administration of Medication policy, last reviewed 9/15/25, that indicated The facility will ensure that each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications . The IDT in consultation with the primary physician for the resident will conduct an assessment of the resident's cognitive, physical, and visual ability to carry out this responsibility . The interdisciplinary assessment will be completed in the electronic medication record . After the IDT and primary physician review the assessment and determines the resident can safely self-administer, or self-administer and safely store medications at bedside, .the care plan for the resident will reflect the self-administration . If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted . The nurse is responsible for .removal of expired medications.3.1-11(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure the development of a resident's comprehensive care plan for 1 of 1 residents reviewed for Respiratory Care and 1 of 5 residents reviewed for medications. (Resident 11, Resident 33)Findings include: 1. On 12/09/25 at 10:44 A, M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to type 2 diabetes mellitus, unspecified, thoracic, thoracolumbar and lumbosacral intervertebral disc disorder, and atrial fibrillation. The current admission Minimum Data Set (MDS) Assessment indicated Resident 33 was cognitively intact. Resident 33 required partial to moderate assistance with toileting and dressing, and supervision with transferring. During the 7 day look back period the resident did not require oxygen therapy. Current physician orders included, but were not limited to:Oxygen at 2 liters/minute per nasal cannula as needed for SPO2 <90% as needed dated 10/31/25.Change oxygen tubing, humidifier bottle, and nebulizer circuit weekly every night shift every Sun Label when changed dated 12/04/25. The current record lacked a care plan for oxygen use. During an interview on 12/10/25 at 2:15 P.M., the Director of Nursing (DON) indicated there should be a care plan for oxygen. 2. On 12/9/25 at 1:57 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, epilepsy. The most current Annual Minimum Data Set (MDS) Assessment, dated 11/4/25, indicated that Resident 11 had mild cognitive impairment, received an anticonvulsant during the 7-day lookback period, and had a diagnosis of epilepsy. Physician orders included, but were not limited to: Valproic Acid Oral Solution (an anticonvulsant medication) 250 milligrams (mg) per 5 milliliters (mL) - Give 750 mg via G-Tube two times a day related to idiopathic epilepsy, dated 10/3/25. A care conference was completed on 9/9/25 with the resident's family member in attendance. Care plans were reviewed. The clinical record lacked a care plan related to Resident 11's diagnosis of epilepsy or monitoring of the anticonvulsant medication. During an interview on 12/19/25 at 11:36 A.M., the Director of Nursing (DON) indicated that Resident 11 should have a care plan related to epilepsy and anticonvulsant medication. During an interview on 12/10/25 at 12:08 P.M., MDS Coordinator 15 indicated that Resident 11 did not have a care plan related to epilepsy and anticonvulsant medication, and it would be added. On 12/11/25 at 12:50 P.M., the Administrator provided a current Comprehensive Care Plans and Revisions policy, last reviewed 8/29/25, that indicated The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(a)3.1-35(b)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were followed and obtained a residents daily weight for 1 of 1 residents reviewed for hospitalizations. (Resident 81) Finding includes: On 12/9/25 at 10:51 A.M., Resident 81's clinical record was reviewed. Resident 81 was admitted on [DATE]. Diagnoses included, but were not limited to, heart failure. The most recent admission Minimum Data Set (MDS) Assessment, dated 10/24/25, indicated Resident 81 was cognitively intact, required substantial assistance (staff do more than half of the work) for toileting, and received diuretic medication. Physician orders included, but were not limited to: Daily weight for 60 days: Notify MD/NP if greater than three pound gain in 24 hours or greater than five pound gain in seven days. Weight to be obtained is dry weight at 0700; Follow medication instructions for (as needed) Bumetanide 1 MG in the morning related to congestive heart failure for 60 days; Start date 11/12/25Bumetanide Oral Tablet 1 MG (a diuretic medication)Give 1 mg by mouth one time a day related to congestive heart failure; Start date 11/8/25 The clinical record, including electronic medication administration record, documents, progress notes, and vitals, indicated Resident 81's weight was not obtained on 11/15/25, and showed a nine pound weight gain on 11/16/25. On 12/11/25 at 1:50 P.M., the Administrator provided a policy titled Physician Orders, revised 2/26/24, that indicated A physician, physician assistant or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. 3.1-35(g)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper oxygen services were provided according to physician orders for 1 of 1 residents reviewed for respiratory care. (Resident 33) Findings include: On 12/9/25 at 10:02 A.M., Resident 33 was observed sitting in a wheelchair wearing oxygen (O2) at 2 Liters/Nasal Cannula connected to a concentrator. The concentrator had a humidification bottle attached with no water present. On 12/10/25 at 9:40 A.M., Resident 33 was out of the room and the O2 concentrator was observed with the humidification with no water present. On 12/09/25 at 10:44 A, M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to type 2 diabetes mellitus, unspecified, thoracic, thoracolumbar and lumbosacral intervertebral disc disorder, and atrial fibrillation. The current admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 33 was cognitively intact. Resident 33 required partial to moderate assistance with toileting and dressing, and supervision with transferring. During the 7 day look back period the resident did not require oxygen therapy. Current physician orders included, but were not limited to:Oxygen at 2 liters/minute per nasal cannula as needed for SPO2 <90% as needed dated 10/31/25.Change oxygen tubing, humidifier bottle, and nebulizer circuit weekly every night shift every Sun Label when changed dated 12/04/25. The current record lacked a care plan for oxygen use. On 12/11/25 at 9:00 A.M., the Director of Nursing (DON) indicated the humidification bottle should be full of water and filled as needed. On 12/11/25 at 12:50 P.M., the Administrator provided a current Comprehensive Care Plans and Revisions policy, last reviewed 8/29/25, that indicated The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. 3.1-47(a)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 7 residents (Resident 28 and Resident 75) observed during the medication pass. There were 25 opportunities observed with 2 errors, resulting in an 8 percent medication error rate. Findings include:1. On 12/11/25 at 7:56 A.M., Registered Nurse (RN) 3 was observed preparing a Basaglar Kwikpen for insulin administration for Resident 28. RN 3 indicated that Resident 28 had a standing order for 40 units of insulin two times a day. RN 3 set the pen to 40 units, attached the needle, and administered the insulin to Resident 28 in her abdomen. RN 3 did not prime the insulin pen prior to administration. During an interview on 12/11/25 at 8:00 A.M., RN 3 indicated that the pen was supposed to be primed with one or two units of insulin prior to setting the dosage. On 12/11/25 at 9:15 A.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most current Annual Minimum Data Set (MDS) Assessment, dated 9/2/25, indicated Resident 28 was cognitively intact and received insulin 7 out of 7 days during the lookback period. Physician orders included, but were not limited to:Basaglar KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter (mL) (insulin glargine - a long-acting insulin) - Inject 40 units subcutaneously two times a day for diabetes mellitus, dated 3/10/25 On 12/11/25 at 9:36 A.M., the instruction manual for Basaglar Kwikpen, revised November 2023, was reviewed. The instruction manual indicated Prime before each injection. Priming means removing the air from the needle and cartridge that may collect during normal use. It is important to prime your pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. On 12/11/25 at 12:50 P.M., the Administrator provided a current Insulin Use policy, dated 5/19/25, that indicated Remove the cap from the pen needle and prime the insulin pen by pointing it up in the air, dialing one or two units on the insulin pen, and then fully pressing the plunger or by following the manufacturer's instructions. A drop of insulin should appear at the needle tip. Repeat the priming procedure until a drop appears. 2. On 12/11/25 at 8:22 A.M., Licensed Practical Nurse (LPN) 11 was observed administering Advair (a dry powder inhaler) to Resident 75. After the dose was administered, LPN 11 did not offer or encourage the resident to rinse his mouth. On 12/11/25 at 9:27 A.M., Resident 75's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated Resident 75 was cognitively intact and required setup assistance for eating. Physician orders included, but were not limited to:Advair Diskus Aerosol Powder Breath Activated 250-50 micrograms per dose (Fluticasone-Salmeterol - an inhaled steroid medication used to improve symptoms of COPD) - One inhalation orally two times a day related to COPD. Rinse mouth after use, dated 7/28/25. On 12/11/25 at 9:45 A.M., the Advair Diskus instruction manual, revised June 2023, was reviewed. The instruction manual indicated After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis. On 12/11/25 at 10:01 A.M., the Director of Nursing (DON) indicated that the resident should rinse out their mouth after using a dry powder inhaler if the order said rinse mouth or if the inhalant was a steroid. On 12/11/25 at 12:50 P.M., the Administrator provided a current Dry Power Inhaler Use policy, revised 5/19/25, that indicated Have the patient rinse the mouth with water to remove medication from the mouth. Provide an emesis basin if necessary, because the patient should spit out the water, not swallow it. 3.1-48(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were followed in 1 of 1 residents observed for catheter care. (Resident 6) Hand hygiene was not performed correctly.Finding includes: On 12/10/25 at 9:03 A.M., Certified Nurse Aide (CNA) 7 and CNA 9 were observed performing catheter care for Resident 6. Prior to donning gown and gloves, CNA 9 washed her hands for eight seconds. After performing the care and prior to emptying the catheter bag, CNA 9 washed her hands for 12 seconds. After all care was completed and prior to leaving the room, CNA 9 washed her hands for seven seconds and CNA 7 washed her hands for 13 seconds. During an interview on 12/11/25 at 7:35 A.M., the Infection Preventionist (IP) indicated that staff were trained to wash their hands for at least 40 seconds, but preferably 60 seconds. On 12/11/25 at 12:50 P.M., the Administrator provided a current Hand Hygiene policy, revised 10/28/25, that indicated This facility will utilize the Lippincott procedure: Hand Hygiene Procedure. On 12/11/25 at 1:14 P.M., the Administrator provided the [NAME] Hand Hygiene Procedure, revised 9/15/25. It indicated Work up a generous lather by vigorously rubbing your hands together .for at least 20 seconds. 3.1-18(l)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the staff was adequately trained to use an external catheter device for 1 of 1 residents observed with external urinary catheter. (Resident 1) Findings include:On 12/9/25 at 11:33 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified urinary incontinence, muscle weakness, and malignant neoplasm of the ascending colon The current admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 1 was cognitively intact. Resident 1 required substantial maximum assistance for toileting, hygiene, and transferring and utilizing an external catheter appliance at night. Current Physician Orders included, but were not limited to:External catheter appliance urine collection system - Ensure system is level with the height of the bed when on every shift related to UNSPECIFIED URINARY INCONTINENCE dated 11/14/25.External catheter appliance to cannister drainage for diagnosis of Urinary Incontinence per manufacturer instructions. Connect the tubing to the eternal catheter appliance urine collection cannister; connect the canister to the unit; turn the unit on. Replace catheter every 8 hours dated 11/14/25.The current urinary incontinence care plan dated 11/14/25 included, but were not limited, to the following interventions:Resident and resident's family request the use of external catheter device dated 11/24/25.Will have no skin breakdown related to urinary incontinence and the use of external catheter appliance dated 11/14/25. During an interview on 12/09/25 at 8:37 A.M., Resident 1 was concerned that some of the staff did know how to use the external catheter appliance.During an interview on 12/10/25 at 9:14 A.M., Certified Nursing Assistant (CNA) 17 indicated she was not sure how to use the external catheter appliance. During an interview on 12/10/25 at 9:20, Licensed Practical Nurse (LPN) 19 indicated she had no formal education on the external catheter appliance. During an interview on 12/10/25 at 9:22 A.M., LPN 5 indicated there was no formal education on the external catheter device, but she would do individual training with a return demonstration, but would there was documentation of the education that was done. On 12/11/25 at 11:50 A.M., the Administrator provided a current policy Education and Training revised 10/1/25. The policy indicated .The facility will need to ensure staff are trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program . 3.1-14(i)3.1-14(p)(6)