

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2024
NAME OF PROVIDER OR SUPPLIER  Parkview Haven		STREET ADDRESS, CITY, STATE, ZIP CODE  101 Constitution Dr Francesville, IN 47946	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>32788</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 139 and 9)</p> <p>Findings include:</p> <p>1. On 5/28/24 at 11:17 a.m., Resident 139 was observed seated in her recliner in her room. The nebulizer machine on her bedside table was on and she had the mask in place over her mouth and nose. The resident indicated her nebulizer treatment was in progress. There were no staff present in the room or near the room.</p> <p>The resident's record was reviewed on 5/30/24 at 2:35 p.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and atrial fibrillation.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 5/17/24, indicated the resident was cognitively intact.</p> <p>A Physician's Order, dated 5/16/24, indicated ipratropium-albuterol solution 0.5 mg (milligrams)-3 mg/3 ml (milliliters) two times a day.</p> <p>There was a lack of any physician's order for self-administration of the medication or any self administration of medication assessment.</p> <p>During an interview on 5/31/24 at 10:31 a.m. with the Director of Nursing (DON), he indicated there were no orders for self-administration of the nebulizer treatment and no self-administration assessment had been completed.</p> <p>A facility policy, titled, Oral Inhalation Administration, received from the DON as current, indicated .Nebulizer Administration .13. Remain with resident for the treatment unless the resident has been assessed and authorized to self-administer .</p> <p>45666</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a random observation on 5/28/24 at 4:14 p.m., a bottle of sore throat spray (phenol anesthetic) was sitting on top of the dresser. During an interview at the time, Resident 9 indicated she received the medication from her most recent hospital stay and kept it in her room in case she needed to use it.</p> <p>On 5/29/24 at 11:06 a.m., the sore throat spray was noted on top of the dresser.</p> <p>Resident 9's record was reviewed on 5/29/24 at 4:04 p.m. Diagnoses included, but were not limited to, fracture of the left tibia and type 2 diabetes mellitus.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact for daily decision making.</p> <p>There were no orders for a throat spray or self-administration of the medication. There was also no self-administration of medication assessment completed.</p> <p>During an interview on 5/31/24 at 9:56 a.m., the Director of Nursing indicated he had no further information to provide.</p> <p>A policy for medication self administration was requested, but none were provided prior to exit.</p> <p>3.1-11(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure an area of discoloration was assessed and monitored for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 1)</p> <p>Finding includes:</p> <p>On 5/28/24 at 11:26 a.m., Resident 1 was sitting in the recliner in her room. She had a discoloration noted to the outer portion of her right calf. At the time, Resident 1 indicated her lower leg sometimes bothered her, so she would put some cream on the affected area.</p> <p>On 5/30/24 at 11:37 a.m., Resident 1 was sitting in the recliner in her room. The outer portion of her right calf was discolored. The resident indicated she had put some cream on it, but it was still hurting.</p> <p>Resident 1's record was reviewed on 5/29/24 at 12:13 p.m. Diagnoses included, but were not limited to, venous insufficiency and peripheral vascular disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/24, indicated the resident was moderately impaired for daily decision making.</p> <p>A Physician's Order, dated 2/15/24, indicated a weekly skin assessment was to be performed.</p> <p>The May 2024 Medication Administration Record (MAR) indicated the weekly skin assessment was completed on 5/3, 5/6, 5/10, 5/13, 5/17, 5/20, 5/24, 5/27, and 5/31/24.</p> <p>There was no documentation related to the discoloration on the outer right calf.</p> <p>During an interview on 5/31/24 at 3:02 p.m., the Director of Nursing indicated there was no recent documentation related to a discoloration on the right calf.</p> <p>A policy for skin monitoring was requested but none were provided prior to exit.</p> <p>3.1-37(a)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure orders for a pressure ulcer dressing were specific and dressings were in place per physician's orders for 1 of 1 residents reviewed for pressure ulcers. (Resident 1)</p> <p>Finding includes:</p> <p>On 5/28/24 at 11:36 a.m., Resident 1 was observed in her room. She had a nude colored dressing on her right buttocks. There was no date on the dressing. The resident, at that time, indicated she had a wound on her buttocks that caused her some pain. She thought the staff were putting cream on the area.</p> <p>During an observation of the wound on 5/31/24 at 1:29 p.m., the Director of Nursing (DON) wiped calmoseptine from Resident 1's buttocks. There was no dressing noted to either side of the buttocks. There were two discolored areas on the middle cleft on both cheeks. There were no open areas noted at the time.</p> <p>Resident 1's record was reviewed on 5/29/24 at 12:13 p.m. Diagnoses included, but were not limited to, chronic kidney disease, venous insufficiency, and peripheral vascular disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/24, indicated the resident was moderately impaired for daily decision making.</p> <p>A Care Plan, dated 5/11/24, indicated the resident had a pressure ulcer to the left and right gluteal cleft. Interventions included, but were not limited to, assess and record the condition of the skin surrounding the pressure ulcer, assess the pressure ulcer, and keep the area clean and dry.</p> <p>A Physician's Order, dated 5/11/24, indicated to change dressing to the left buttock every two days or if soiled as needed.</p> <p>The May 2024 Medication Administration Record (MAR) indicated the left buttock dressing was completed on 5/11/24, 5/21/24, 5/25/24, and 5/27/24. On 5/13/24, 5/15/24, 5/17/24, 5/19/24, 5/23/24, and 5/31/24 the wound was left open to air. On 5/29/24 the resident refused the treatment.</p> <p>A Physician's Order, dated 2/15/24, indicated a weekly skin assessment was to be completed.</p> <p>The May 2024 MAR indicated the weekly skin assessment was completed on 5/3, 5/6, 5/10, 5/13, 5/17, 5/20, 5/24, 5/27, and 5/31/24.</p> <p>A Nurses' Note, dated 5/11/24 at 8:32 p.m., indicated the resident requested the nurse to assess an area of discomfort on the buttock. There were two small areas near the middle cleft on both cheeks. The area to the right cheek measured 2 cm (centimeters) by 3 cm. The skin surrounding was reddened and there was a slightly raised area with a small opening. The left side wound measured 1 cm by 2 cm. It was slightly raised with a small opening in the skin. There were no signs of infection or drainage noted. Barrier cream and a dressing was applied to the left cheek.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Wound Management Detail Report, dated 5/16/24 at 10:42 a.m., indicated the resident had a stage 2 pressure area to the right buttock measuring 1.5 cm by 2 cm. The wound bed was red with granulation tissue. The treatment was calmoseptine on the wound area.</p> <p>There were no further wound assessments or measurements for either of the pressure areas.</p> <p>During an interview on 6/3/24 at 1:40 p.m., the DON indicated he did not recall the resident having any open areas to the buttocks and a nurse may have added the generic order for the dressing to the area. He was not aware of that order.</p> <p>A policy for wound care and monitoring was requested but none were provided prior to exit.</p> <p>3.1-40(a)(2)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>32664</p> <p>Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 1 of 3 residents reviewed for accidents. (Resident 23)</p> <p>Finding includes:</p> <p>On 5/29/24 at 2:56 p.m. and on 5/30/24 at 3:01 p.m., Resident 23 was observed lying in bed with her eyes closed. A wheelchair was next to the resident's bed. The wheelchair had a cushion in the seat area. There was not a Dycem (non slip mat) observed on top or underneath the cushion.</p> <p>Record review for Resident 23 was completed on 5/29/24 at 12:29 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, and history of falling.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/23/24, indicated the resident was cognitively impaired. The resident used a wheelchair and required a substantial maximum assistance with transfers. The resident had 3 falls including 1 with an injury since the previous assessment.</p> <p>A Care Plan, dated 12/8/21 and revised 5/28/24, indicated the resident was at risk for falls due to weakness at times, impaired mobility and balance, impaired cognition, incontinence, history of falls, impaired vision, and poor safety awareness. An intervention included to add a Dycem to the wheelchair.</p> <p>The May 2024 Physician's Order Summary indicated an order for a Dycem under the wheelchair cushion to prevent slipping out of the wheelchair.</p> <p>A Progress Note, dated 5/12/24 at 5:56 p.m., indicated the resident slid from her wheelchair to the floor onto her buttocks.</p> <p>During an interview on 5/30/24 at 3:07 p.m., RN 1 indicated the resident was supposed to have a Dycem in her wheelchair. She then went and observed the resident's wheelchair. There was no Dycem on top of the wheelchair cushion. She pulled the cushion up and there was no Dycem underneath the wheelchair cushion. The RN then proceeded to cut a piece of Dycem from a roll to place it into the resident's wheelchair.</p> <p>A policy for fall interventions was requested but none were provided prior to exit.</p> <p>3.1-45(a)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>32788</p> <p>Based on observation and interview, the facility failed to post a current daily nurse staffing posting. This had the potential to affect all 37 residents residing in the facility.</p> <p>Finding includes:</p> <p>On 6/3/24 at 10:04 a.m., the Nursing Staffing sheet was posted on the bulletin board near the Nurse's Station. The posting was dated 5/30/24.</p> <p>On 6/3/24 at 11:08 a.m., the Nursing Staffing sheet was posted on the bulletin board near the Nurse's Station. The posting was dated 5/30/24.</p> <p>During an interview on 6/3/24 at 12:08 p.m., the Assistant Director of Nursing (ADON) indicated the Unit Coordinator or Medial Records staff usually updated the staffing posting daily. She was not sure why the posting had not been updated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a chronic wound was placed in enhanced barrier precautions (EBP) for high contact resident care activities for 1 of 1 residents reviewed for EBP (Resident 29) and no education provided to staff as part of the facility's infection control program. This had the potential to affect all 37 residents residing in the facility.</p> <p>Finding includes:</p> <p>On 5/28/24 at 3:09 p.m., Resident 29's room was observed. There were no signs for enhanced barrier precautions on the door or inside of the room. There was no personal protective equipment near the entrance of the room or inside of the resident's room.</p> <p>During an interview on 6/3/24 at 10:18 a.m., LPN 1 indicated she had never had a resident on enhanced barrier precautions. They had at least one wound in the facility at that time and the resident was not on any type of precautions.</p> <p>Resident 29's record was reviewed on 6/3/24 at 9:00 a.m. Diagnoses included, but were not limited to, adult failure to thrive and cancer to the maxillary sinus.</p> <p>The Admission Minimum Data Set assessment, dated 2/28/24, indicated the resident was moderately impaired for daily decision making.</p> <p>A Wound Assessment, dated 5/29/24 at 4:02 p.m., indicated the resident had a stage 2 pressure ulcer above the left buttock measuring 0.5 centimeters (cm) by 0.5 cm. The wound bed was filled with granulation tissue. The wound had been present since his admission on 2/23/24.</p> <p>There were no physician's orders for enhanced barrier precautions.</p> <p>A policy for EBP was requested but none were provided prior to exit.</p> <p>During an interview on 6/3/24 at 12:07 p.m., the Assistant Director of Nursing indicated that she had not implemented any enhanced barrier precautions in the building as she still needed to read up on what to do for the EBP. She had not provided any education to the facility staff at this time.</p> <p>3.1-18(b)</p>		