STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155853	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 32788 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for self-medication administration prior to leaving medications at the bedside, for 1 of 1 random observations of medications left at bedside. (Resident 7) Finding includes: On 4/16/24 at 10:32 a.m., Resident 7 was observed sitting up in her bed putting on makeup. There was a medicine cup with multiple pills in it on her bedside table. She indicated the pills were hers and she was not sure how long they had been there. The resident's record was reviewed on 4/17/24 at 2:24 p.m. Diagnoses included, but were not limited to, hypertension, heart failure, and atrial fibrillation. The Significant Change Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was moderately cognitively impaired. There was a lack of any Physician's Orders for self-administering medications or any self administration of medications assessment. During an interview with the Director of Nursing (DON) on 4/16/24 at 2:05 p.m., she indicated the pills should not have been left in the resident's room and she had not been assessed to self-administer medications. 3.1-11(a)

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: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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. 45666 Based on record review and interview, the facility failed to ensure a resident's representatives were notified of a new fracture acquired after a fall for 1 of 2 residents reviewed for falls. (Resident 29) Finding includes: Resident 29's record was reviewed on 4/18/24 at 2:49 p.m. Diagnoses included, but were not limited to, fracture of right acetabulum (a part of the pelvis) and other parts of pelvis. The Significant Change Minimum Data Set (MDS) assessment, dated 2/14/24, indicated the resident was severely cognitively impaired for daily decision making. She had one fall since admission that resulted in a major injury. A Care Plan, updated 1/31/24, indicated the resident was at risk for falls related to weakness, history of falls, and confusion. Interventions included, but were not limited to, dycem in wheelchair, anticipate needs, and ensure resident's call light is within reach. A Progress Note, dated 1/31/2024 at 7:49 p.m., indicated the resident had slipped out of the wheel chair onto the dining area floor. The resident was stable and all vital signs were within normal limits. There were no new injuries or skin issues present. The Nurse Practitioner was notified and new orders for a stat x-ray to back/head were ordered. The Director of Nursing (DON) and the resident's son and daughter were notified. A Progress Note, dated 1/31/2024 7:56 p.m., indicated the x-ray results were negative. The resident's son and daughter were both contacted as well as the Nurse Practitioner and the DON. The Radiology Results Report, dated 1/31/24 at 7:10 p.m., indicated mild compression fractures of L1 and L3 (lumber vertebrae in the spine). During an interview on 4/19/24 at 2:01 p.m., the DON indicated she was unable to find documentation related to the family being updated on the fractures. The DON was waiting to talk to the Physician to determine if the fractures were old. Upon review of older x-rays, one of the fractures was determined to be old, however there was no documentation of the family being updated. 3.1-5(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Park Place Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10820 Park Place Saint John, IN 46373	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 Based on record review and interview, the facility failed to ensure care planning conferences were completed timely and residents or Responsible parties were invited to attend and participate in the care planning conferences for 2 of 2 reviewed for care planning. (Residents 1 and 30) Findings include: 1. During an interview on 4/16/24 at 10:37 a.m., Resident 1 indicated he had not been involved in any care plan meetings. Resident 1's record was reviewed on 4/19/24 at 8:42 a.m. He was admitted into the facility on [DATE]. Diagnoses included, but were not limited to, spinal stenosis, heart failure, and dementia. He had a Quarterly Minimum Data Set (MDS) assessment completed on 5/16/23 and 11/13/23. An Annual MDS assessment was completed on 8/15/23. A Significant Change in Status MDS assessment was completed on 2/13/24. A Social Service Initial Evaluation, dated 8/22/22 at 9:17 a.m., indicated the resident was present during the evaluation and his spouse was on the phone. During an interview on 4/18/24 at 3:31 p.m., the Social Services Assistant indicated there were no other care plan meetings listed on the electronic health record. It had not popped up that a care plan meeting was due with each comprehensive assessment. 48055 2. During an interview on 4/16/24 at 10:54 a.m., Resident 30 indicated he was not invited to his recent care conference. The record for Resident 30 was reviewed on 4/16/24 at 9:25 a.m. Diagnoses included, but were not limited to, chronic kidney disease, stage 3, obesity, chronic atrial fibrillation, shortness of breath, and generalized edema. The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was cognitively intact. A care conference was held with the resident's family on 3/29/24. Resident 30 was not in attendance and was not invited. During an interview on 4/21/24 at 2:21 p.m., the Social Service Assistant indicated the resident was not invited to the last care plan meeting due to the family having concerns that the resident became frustrated at the last care plan meeting, and they wanted to meet without him. 3.1-35(d)(2)(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155853	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45666 Based on observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to completing nail care for 1 of 1 resident reviewed for ADL care. (Resident 1) Finding includes: During an observation on 4/16/24 at 10:36 a.m., Resident 1 was in bed. His fingernails were noted to be long and dirty. During an observation and interview on 4/17/24 at 10:40 a.m., Resident 1 indicated he would like to have his fingernails cleaned and trimmed. The nails were observed to be long and dirty. Resident 1's record was reviewed on 4/19/24 at 8:42 a.m. Diagnoses included, but were not limited to, spinal stenosis, heart failure, and dementia. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 2/13/24, indicated the resident was moderately cognitively impaired for daily decision making. A Care Plan, reviewed on 2/24/23, indicated the resident had an ADL self-care performance deficit related to spinal stenosis and inability to care for self. Interventions included, but were not limited to, the resident required extensive assistance by one staff for personal hygiene and oral care. During an interview on 4/17/24 at 3:16 p.m., the Administrator indicated she would have someone go address his nails. She did not provide any further information. 3.1-38(a)(3)(E)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45666 Based on record review and interview, the facility failed to ensure a resident with a urinary tract infection (UTI) received the necessary treatment and services related to completing an ordered laboratory test timely for 1 of 1 residents reviewed for urinary tract infections. (Resident 14) Finding includes: Resident 14's record was reviewed on 4/18/24 at 9:55 a.m. Diagnoses included, but were not limited to, overactive bladder, history of UTI, and retention of urine. The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/24, indicated the resident was cognitively intact for daily decision making. The resident was always incontinent of bladder. A Care Plan, dated 5/2/23, indicated the resident had a risk for impaired urinary elimination related to an overactive bladder. Interventions included, but were not limited to, monitor for signs and symptoms of UTI, monitor frequency, and evaluate character of urine. A Progress Note, dated 12/27/2023 at 9:31 p.m., indicated the resident had complaints of urinary frequency and burning. A new order was obtained for a urinalysis culture and sensitivity (UA/C+S). A Progress Note, dated 1/7/2024 at 3:53 p.m., indicated the UA (urinalysis) was collected and placed in the fridge on floor one. The laboratory was notified for pickup the next morning. A Progress Note, dated 1/9/2024 at 1:52 p.m., indicated a staff member called the laboratory to follow up. The phlebotomist who came to pick up the UA sample stated that it was not in the fridge yesterday morning. The UA sample was now lost and a new one was needed. A Progress Note, dated 1/11/2024 at 5:47 a.m., indicated the UA specimen was needed. The attempt to obtain this shift was unsuccessful. The resident refused a straight catheter procedure at this time. The UA with reflex indicated the sample was collected on 1/9/24 at 4:00 p.m. and the results were reported on 1/15/24 at 7:14 a.m. A Progress Note, dated 1/16/2024 at 1:36 a.m., indicated a new order was received to start the resident on oral macrobid (antibiotic) 100 milligrams every 12 hours for 7 days for UTI (urinary tract infection). The order was noted and the medication was to start this am. The resident was notified of the new order. During an interview on 4/18/24 at 3:19 p.m., the Director of Nursing indicated the UA should have been collected and sent to the laboratory more timely. 3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Park Place Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10820 Park Place Saint John, IN 46373	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 32788 Based on observation, record review, and interview, the facility failed to ensure a gastrostomy tube (g-tube) was checked for placement prior to medication administration for 1 of 11 residents observed during medication pass. (Resident 8) Finding includes: On 4/18/24 at 11:02 a.m. RN 1 was observed preparing Resident 8's g-tube medication, carbidopa/levodopa 25-100 mg (milligrams). She crushed the medication, then diluted it in the medication cup with 30 cc (cubic centimeters) of water. She donned gloves, opened the cap to the g-tube, attached the empty piston syringe to the resident's g-tube, and flushed the tube with 60 cc of water. She administered the diluted medication and then flushed the g-tube with another 60 cc of water. She removed the piston syringe and replaced the cap to the g-tube. She had not checked the g-tube for placement prior to administering the medication. During an interview with RN 1 on 4/18/24 at 11:12 a.m., she indicated she had not checked the g-tube for placement prior to administering the medication and she probably should have done that. She was unsure of the facility policy on checking for g-tube placement. During an interview with the Director of Nursing (DON) on 4/18/24 at 11:33 a.m., she was made aware RN 1 had not checked the g-tube for placement prior to administering the medication. The DON indicated she would provide the facility policy. A facility policy, titled Gastrostomy/Jejunostomy Feeding and Medication Administration, received from the DON as current, indicated, .Verify placement of gastrostomy tube using the following methods: .a. If client is receiving PPI medications or if a continuous feeding is being interrupted, nurse will measure the external tube length in centimeters and compare to the original measurement to verify placement .b. If client is not receiving PPI medications and there has been no oral or enteral intake for greater than one hour, the nurse will utilize two methods of placement verification, measurement of external tube length and pH testing of aspirate . 3.1-44(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 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. 32664 Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 2 residents reviewed for oxygen. (Resident 11) Finding includes: On 4/17/24 at 1:02 p.m. and again at 2:54 p.m., Resident 11 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate in between 2.5 and 3 liters. Record review for Resident 11 was completed on 4/17/24 at 2:45 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, anxiety, dementia, and COPD (chronic obstructive pulmonary disease). The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was cognitively impaired. The resident received oxygen therapy. A Care Plan, dated 10/13/23, indicated the resident had an ADL (activities of daily living) functional self care and mobility performance deficit related to inability to care for self. The resident had a diagnosis of COPD and was on hospice care. An intervention included to administer oxygen per nasal cannula at 2 liters. The April 2024 Physician's Order Summary indicated oxygen per nasal cannula at 2 liters every shift and as needed. During an interview on 4/17/24 at 2:56 p.m., RN 2 indicated the resident was supposed to be on 2 liters of oxygen. The RN then proceeded to check the resident's flow rate and it was set in between 2.5 and 3 liters. She changed the resident's oxygen flow rate to 2 liters. 3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45666 Based on observation and interview, the facility failed to serve food under sanitary conditions related to touching residents' food after touching non-food items. This had the potential to affect 15 of 15 residents who received food from the unit kitchen. (100 Unit Kitchen) Finding includes: On 4/18/24 at 12:10 p.m., lunch meal service was observed. Cook 1 had washed her hands and donned clean gloves. She touched the outside of a container and removed the clear plastic wrap from the top with her gloved hands. She reached into the container and picked up a roll with the same gloved hands and placed it on a plate. Cook 1 received another plate, opened the same container with the same gloved hands, reached in and picked up a roll and placed it on the plate. Cook 1 did not change her gloves or perform hand hygiene. During an interview at the time of observation, Cook 1 indicated she had a pair of tongs that she should have been using to pick up the rolls, however she had forgot to use them. During an interview on 4/18/24 at 12:12 p.m., the Head Cook indicated Cook 1 should have used the tongs to pick up the rolls. 3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 32664 Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy to reduce antibiotic resistance, related to hospice prescribing an antibiotic for a urinary tract infection (UTI) without a urinalysis and culture completed for 1 of 1 residents reviewed for antibiotic use. (Resident 11) Finding includes: Record review for Resident 11 was completed on 4/17/24 at 2:45 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, anxiety, dementia, and COPD (chronic obstructive pulmonary disease). The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was cognitively impaired. The resident received hospice services. A Physician's Order, dated 3/17/24-3/22/24, indicated Macrobid (antibiotic) 100 mg (milligrams) twice a day for 5 days for a UTI. A Progress Note, dated 3/16/24 at 8:35 p.m., indicated the resident was confused and asked to be brought to the bathroom to urinate multiple times in an hour. Hospice was notified and ordered an antibiotic for a UTI. There was no documentation to indicate a urinalysis had been completed to diagnose a UTI. There was no documentation to indicate the resident received the antibiotic for a true infection. During an interview on 4/19/24 at 10:09 a.m., the Director of Nursing indicated the resident had been put on the antibiotic for comfort measures. A urinalysis had not been completed and the resident did not meet the criteria for an antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155853	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Health and Wellness Center	10820 Park Place Saint John, IN 46373

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on record review and interview, the facility failed to administer the influenza (flu) vaccine for 3 of 5 residents reviewed for immunizations. (Residents 32, 8 and 2) Findings include: The facility's Infection Control Program, which included resident immunizations, was reviewed on 4/19/24 at 11:00 a.m. There was a lack of documentation to indicate the following residents were offered or received the influenza vaccine for the 2023-2024 flu season. 1. Resident 32 was admitted on [DATE]. There was no signed consent or documentation the resident received the influenza vaccine for 2023-2024 flu season. 2. Resident 8 was admitted on [DATE]. There was no signed consent or documentation the resident received the influenza vaccine for 2023-2024 flu season. 3. Resident 2 was admitted on [DATE]. There was no signed consent or documentation the resident received the influenza vaccine for 2023-2024 flu season. During an interview on 4/19/24 a 3:30 p.m., the Director of Nursing indicated the pharmacy did a vaccination clinic at the facility. They were unable to provide any documentation the above residents had been offered or had received the 2023-2024 influenza vaccine. 3.1-13(a)