STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155746	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Haven	101 Constitution Dr Francesville, IN 47946

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's Baseline Care Plan was complete and accurate related to the use of half side rails for 1 of 7 residents reviewed for accidents. (Resident 183) Finding includes: During an observation and interview on 6/18/25 at 11:15 a.m., Resident 183 was observed sitting up in bed, there were half side rails on each side of the bed. The resident indicated she had a couple of falls out of her bed since she arrived to the facility. On 6/20/25 at 4:45 p.m., Resident 183 was observed sitting up in bed. She indicated the facility got her a longer bed and it was comfortable for her. There were half side rails observed on each side of the bed. Resident 183's record was reviewed on 6/19/25 at 3:52 p.m. Diagnoses included, but were not limited to, lymphedema of the left lower extremity, colon cancer, and dementia. The resident admitted to the facility on [DATE]. An Observation document, titled, Restraints/Adaptive Equipment - Side Rails Assessment and Consent, dated 6/10/25 at 11:36 p.m., indicated siderails were to be used as an enabler due to the resident's weakness. Both top half side rails were to provide assistance with transfers and bed mobility. The Baseline Care Plan, dated 6/10/25, lacked any documentation related to bed mobility limitations and need for half side rails. The admission Minimum Data Set (MDS) assessment, dated 6/17/25, was still in progress. A Care Plan, dated 6/17/25, indicated the resident was at risk for falls. Interventions included, but were not limited to, offer the resident a different bed. During an interview on 6/24/25 at 11:40 a.m., the Director of Nursing indicated the resident had half side rails in place since admission. They had just recently placed her in a longer bed with the same type of side rails per her request. During an interview on 6/25/25 at 12:13 p.m., the Assistant Director of Nursing indicated there should have been an order for the side rails and it should have been on the Baseline Care Plan. (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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Care Plans - Baseline, indicated .1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight hours of the resident's admission 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop and interdisciplinary person-centered care plan. 4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medication and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary . A policy titled, Proper Use of Side Rails, indicated .3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan . 3.1-35(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 record review, and interview, the facility failed to ensure comprehensive care plans were implemented for residents for risk of elopement, pain, and antibiotic therapy for 3 of 15 resident care plans reviewed. (Residents 5, 25, and 6) Findings include: 1. Record review for Resident 5 was complete on 6/19/25 at 4:00 p.m. Diagnoses included, but were not limited to, paranoid schizophrenia, anxiety, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 4/2/25, indicated the resident was cognitively impaired. The resident was independent with bed mobility, transfers, and walking. An Elopement Evaluation, dated 4/7/25, indicated the resident was independent with ambulation. The resident was cognitively impaired and had poor decision-making skills. The resident had a history of wandering into unsafe areas and was a risk for elopement. The section in the assessment related to Elopement Care Plan was not checked as initiated with a comment, already has wanderguard. The June 2025 Physician's Order Summary (POS) indicated an order for a WanderGuard (wearable device that triggers an alarm when resident approaches or enters a restricted zone) to the left leg daily. The record lacked any documentation an elopement care plan had been put into place for the resident. During an interview on 6/20/25 at 11:07 a.m., the Director of Nursing (DON) indicated the resident was at risk for elopement and wore a WanderGuard. The assessment was marked not to initiate a care plan because the staff member already thought there was one in place. There should have been elopement care plan in place and they would implement one. 2. Record review for Resident 25 was completed on 6/20/25 at 11:02 a.m. Diagnoses included, but were not limited to, fibromyalgia (condition that involves widespread body pain), anemia, hypertension, stroke, and anxiety. The Quarterly MDS assessment, dated 5/5/25, indicated the resident was cognitively moderately impaired. The resident had received as needed (PRN) pain medication and non-medication interventions for pain. The resident had occasional pain. The June 2025 POS indicated an order for duloxetine (antidepressant also used to treat muscle pain and stiffness associated with fibromyalgia) 20 mg (milligrams) daily. A Physician's Note, dated 4/18/25 at 7:39 p.m., indicated to continue the duloxetine 20 mg for fibromyalgia pain. The resident was undergoing a gradual dose reduction. The record lacked any documentation that a care plan had been put into place for the resident's pain. During an interview on 6/20/25 at 12:42 p.m., the DON indicated the resident should have had a care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan for pain put into place and they would implement one. 3. Resident 6's record was reviewed on 6/19/25 at 11:50 a.m. Diagnoses included, but were not limited to, retention of urine and fractures of right ulna and left femur. The Quarterly Minimum Data Set (MDS) assessment, dated 4/25/25, indicated the resident was severely cognitively impaired for daily decision making. In the last 7 days, the resident received antibiotic medication. A Physician's Order, dated 12/10/24, indicated sulfamethoxazole-trimethoprim (Bactrim, antibiotic medication) tablet, 800-160 milligrams daily at bedtime. The April, May, and June 2025 Medication Administration Record indicated the resident received Bactrim daily. The record lacked a comprehensive care plan related to antibiotic use. During an interview on 6/24/25 at 11:34 a.m., the Director of Nursing indicated there should have been a care plan related to antibiotic use. 3.1-35(a)

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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** Based on observation, record review and interview, the facility failed to update care plans related to safety and fall interventions for 2 of 15 resident care plans reviewed. (Residents 21 and 8) Findings include: 1. On 6/20/25 at 12:13 p.m., Resident 21's room was observed. The call light cord was wrapped around the upper assist rail on the bed and a black zip tie was holding the cord to the assist rail. There was a silver hand bell on top of the resident's dresser. The resident was not in the room at the time. The record for Resident 21 was reviewed on 6/19/25 at 11:59 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance, general anxiety disorder, and psychotic disorder with delusions. The Quarterly MDS assessment, dated 4/29/25, indicated the resident was cognitively impaired. She required supervision with bed mobility and ambulation. A Care Plan, updated 4/30/25, indicated the resident was at risk for decline in mood related to depression. She had a history of wanting to self-harm and had received inpatient mental health treatment. An intervention, dated 10/29/24, indicated the call light was removed and the resident was provided with a hand bell to use. An Indiana Department of Health reportable incident, dated 10/9/24, indicated the resident was observed with the call light cord wrapped twice around her neck and was sliding down the side of the bed. The resident voiced she was trying to harm herself. The cord was removed, and the resident was sent to the hospital for evaluation. The resident received inpatient mental health treatment and returned to the facility on [DATE]. A Progress Note, dated 10/24/24, indicated the call light cord had been removed from the room and the resident was provided with a bell. A Physician's Order, dated 10/29/24, indicated the resident was to have a call bell beside the bed at all times. During an interview on 6/20/25 at 3:30 p.m., the Director of Nursing indicated the original safety intervention had been to remove the call light cord from the room and use a bell instead. There was a care plan meeting with the resident's family, and it was decided to put the call light back in the room and zip tie it to the bed rail. He was unsure when the meeting had occurred but indicated the care plan should have been updated. 2. On 6/19/25 at 10:31 a.m. Resident 8 was observed seated in her wheelchair in the activity room. There were no anti-lock brakes in place to her wheelchair. On 6/20/25 at 11:47 a.m., Resident 8 was observed seated in her wheelchair in the dining room eating lunch. There were no anti-lock brakes in place to her wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 8 was reviewed on 6/23/25 at 1:06 p.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension, and depression. The Quarterly MDS assessment, dated 5/29/25, indicated the resident was cognitively impaired and had one fall without injury since the prior assessment. A Care Plan, updated 5/20/25, indicated the resident was at risk for falls. An intervention, dated 11/18/22, indicated roll back brakes were added to the wheelchair. A Physician's Order, dated 6/26/24, indicated anti-lock brakes to wheelchair. During an interview on 6/20/25 at 3:30 p.m., the Director of Nursing indicated the anti-lock brakes were a very old intervention and were no longer in place. It should have been discontinued. 3.1-35(d)(2)(B)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to not completing a treatment order as needed and the monitoring and assessment of skin discolorations for 2 of 2 residents reviewed for non-pressure related skin conditions. (Residents 24 and 4) Findings include: 1. On 6/18/25 at 3:52 p.m., Resident 24 was observed sitting in a wheelchair in the dining area. There were reddened raised areas to the right side of her chin and both sides of her nose. On 6/19/25 at 3:57 p.m., Resident 24 was observed sitting in a wheelchair by the nurses' station. The reddened raised areas were still observed to her chin and nose. On 6/20/25 at 3:12 p.m., Resident 24 was observed lying in bed. The reddened raised areas were still observed to her chin and nose. Record review for Resident 24 was completed on 6/20/25 at 12:21 p.m. Diagnoses included, but were not limited to, schizophrenia, Alzheimer's, dementia, anxiety, and bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 5/27/25, indicated the resident was cognitively impaired. The resident required a partial moderate assistance for upper body dressing and a substantial maximum assistance for transfers. A Physician's Note, dated 5/21/25 at 10:58 p.m., indicated to continue the clotrimazole for the dermatitis. The June 2025 Physician's Order Summary (POS) indicated an order for clotrimazole-betamethasone cream (treats fungal skin infections) topically to the dry patches on face twice a day as needed. The June 2025 Medication Administration Record (MAR) indicated the resident had received the as needed cream last on 6/10/25. During an interview on 6/20/25 at 3:14 p.m., RN 1 indicated the resident was admitted to the facility with the rash. The doctor indicated it was xerosis (severe dry skin) and the cream was applied twice a day. The reddened areas had cleared up and then the cream was ordered as needed. She was unaware the reddened areas had appeared on the resident's face again. She would notify the doctor and apply the as needed cream. During an interview on 6/20/25 at 3:34 p.m., the Director of Nursing (DON) indicated they were going to contact the doctor to get the cream as routine instead of as needed. Staff should have been applying the cream to the areas on the resident's face. 2. On 6/18/25 at 4:05 p.m., Resident 4 was observed seated in her wheelchair in the dining room. She had a nickel-sized purple discoloration to the top of her right wrist. On 6/20/25 at 11:48 a.m., Resident 4 was observed seated in her wheelchair in the dining room (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating lunch. The purple discoloration remained to her right wrist. Record review for Resident 4 was completed on 6/20/25 at 12:00 p.m. Diagnoses included, but were not limited to, vascular dementia, atrial fibrillation, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 4/7/25, indicated the resident was cognitively impaired and received antiplatelet medication. She required substantial/maximal assist with toileting, bed mobility, and transfers. A Care Plan, updated 8/30/24, indicated the resident received antiplatelet therapy. The interventions included to observe for signs of active bleeding such as ecchymotic areas (bruising). The Weekly Skin Assessments, dated 6/4/25, 6/11/25, and 6/18/25, were signed off as completed but lacked any documentation of skin discolorations. During an interview on 6/20/25 at 3:30 p.m., the Director of Nursing was made aware of the resident's right wrist skin discoloration. He indicated he would look into it. No further information was provided. A current facility policy, titled Resident Examination and Assessment, indicated, .Physical Exam .8. Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes .Documentation: .3. All assessment data obtained during the procedure . 3.1-37(a)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 7 residents reviewed for accidents. (Resident 1) Finding includes: On 6/18/25 at 3:54 p.m., Resident 1 was observed seated in her wheelchair in the dining room. There were no anti-lock brakes in place to her wheelchair. On 6/19/25 at 10:30 a.m., Resident 1 was observed seated in her wheelchair in the lounge area watching television. There were no anti-lock brakes in place to her wheelchair. On 6/20/25 at 11:48 a.m., Resident 1 was observed seated in her wheelchair in the dining room eating lunch. There were no anti-lock brakes in place to her wheelchair. The record for Resident 1 was reviewed on 6/20/25 at 2:58 p.m. Diagnoses included, but were not limited to, hypertension, vascular dementia, and delusional disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated the resident was cognitively impaired. She had no falls since the prior assessment. She required substantial/maximal assist with bed mobility and transfers. A Care Plan, updated 6/18/25, indicated the resident was at risk for falls. An intervention, dated 4/22/24, indicated to apply anti-lock brakes to the wheelchair. A Physician's Order, dated 6/24/24, indicated to apply anti-lock brakes on the wheelchair. The Medication Administration Record, dated 6/2025, indicated the anti-lock brakes to the wheelchair had been signed out as in place every shift. During an interview on 6/20/25 at 3:30 p.m., the Director of Nursing indicated they had changed out the resident's wheelchair in the last couple months and had not transferred the anti-lock brakes. They should have been in place. 3.1-45(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to monitor nutritional intake for meals for a resident with history of weight loss for 1 of 1 resident reviewed for nutrition. (Resident 6) Finding includes: Resident 6's record was reviewed on 6/19/25 at 11:50 a.m. Diagnoses included, but were not limited to, fractures of right ulna and left femur, cognitive communication deficit, and chronic pain. The Quarterly Minimum Data Set (MDS) assessment, dated 4/25/25, indicated the resident was severely cognitively impaired for daily decision making. She required supervision for eating. She had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on physician-prescribed weight loss regimen. On 12/3/2024, the resident weighed 165 lbs. On 6/2/2025, the resident weighed 145 pounds, which was a 12.12% loss. A Food and Nutrition Care Plan, dated 12/12/24, indicated the resident was consuming 50-75% of meals with no difficulties. She had a weight loss of 19.6 pounds in 6 months. She had been changed to a mechanical soft diet until new dentures were received. Interventions included, but were not limited to, serve and encourage consumption of supplements per order, follow prescribed diet, follow per Nutrition At Risk (NAR), and monitor and record intake. A Dietician Note Monthly Nutrition Weight Change Review, dated 6/12/25 at 2:52 p.m., indicated the resident triggered for significant weight loss over 180 days for the month of June. Weight changes were likely due to poor intakes. She had varied intakes, mostly averaging 50-75% at meals and good acceptance of supplements. The resident was followed in NAR to monitor weight, was discontinued on 5/8/25 after weight stabilized. Her weight had been stable for 90 days. Current interventions remain appropriate. Continue with current interventions, monitoring weight, and plan of care. The Intake - Breakfast, Lunch, and Dinner documentation was reviewed from 4/1/25 through 6/19/25. The following meal consumption amounts were not documented: - Breakfast on 4/12, 4/17, 4/20, 4/24, 4/29, 5/8, 5/19, and 6/2/25 - Lunch on 4/1, 4/23, 5/1, 5/7, 5/20, and 5/22/25 - Dinner on 4/6, 4/11, 4/15, 4/24, 5/3, 5/6, 5/7, 5/13, 5/14, 5/17, 5/18, 5/23, 5/29, 5/31, 6/1, 6/11, and 6/14/25 During an interview on 6/24/25 at 11:00 a.m., the Director of Nursing indicated he had no further information to provide. A facility policy titled, Food and Nutrition Services, indicated .7. Nursing personnel, with the assistance of the food and nutrition services staff, will evaluate (and document as indicated) food and fluid intake of residents with, or at risk for, significant nutritional problems . 3.1-46(a)

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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. Based on observation and interview, the facility failed to ensure medications were properly labeled and stored for 1 of 1 medication carts observed. (North Hall Cart) Finding includes: On 6/24/25 at 2:33 p.m., the North Hall Medication Cart was observed with QMA 2. The following medications were not labeled or stored properly: a. There was a bottle of Vitamin C 500 milligram tablets, Tylenol 500 milligram tablets, and famotidine 20 milligram tablets with Resident 25's name and physician written in black marker. There were no administration instructions for the medications. b. There was a bottle of Tylenol 500 milligram tablets with Resident 25's name and physician written in black marker. There were no administration instructions. c. There was a bottle of aspirin 81 milligram tablets and vitamin D3 25 microgram tablets with Resident 14's name and physician written in black marker. There were no administration instructions. d. There were two bottles of multivitamin tablets with Resident 30's name and physician written in black marker. There were no administration instructions. e. There was a bottle of magnesium citrate 250 milligram tablets, vitamin D3 25 microgram tablets, and vitamin B12 500 microgram tablets with Resident 3's name and physician written in black marker. There were no administration instructions. During an interview on 6/25/25 at 12:14 p.m., the Assistant Director of Nursing (ADON) indicated the medication bottles were brought in by the residents' families. They should have appropriate labels, but the labels the facility currently had would cover up too much of the medication information on the bottle so they had just been writing the names and physician directly on the bottles. A facility policy, Storage of Medications, indicated .3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing . 3.1-25(j)