STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-BLOOMINGTON	155 E BURKS DR BLOOMINGTON, IN 47401

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00298134. Complaint IN00298134 - Unsubstantiated due to lack of evidence. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2019 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 130 Total: 130 Census Payor Type: Medicaid: 118 Other: 12 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on July 09, 2019.	F 0000	The submission of this *Plan of Correction* does not indicate an admission by Golden Living of Bloomington (the "Facility") that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living (of Bloomington). The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities (for Title 16/17 programs). To this end, this *Plan of Correction* shall service as the **credible allegation of compliance** with all state and federal requirement governing the management of this Facility. It is thus submitted as a matter of statute *only*.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

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

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review, the facility failed to ensure the privacy and confidentiality of 2 residents' personal and medical information during 2 random observations (Resident 48 and Resident 277). Findings include: 1.) On 6/26/19, from 10:00 A.M. to 10:10 A.M., the	F 0583	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** F583 - It shall be the practice of Golden Living (of Bloomington) to insure each resident enjoys strict personal privacy and	07/31/2019

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	unattended computer on the medication cart in the hallway by room 112 was observed to display, on the computer screen, the medical record of Resident 49. Information displayed on the screen included, but was not limited to, the resident's name, date of birth, room number, and photograph. Two independently mobile residents and 3 visitors were observed to walk by the computer during that time. 2.) On 6/28/19, from 12:12 P.M. to 12:22 P.M., the unattended computer on the medication cart in the hallway by room 108 was observed to display, on the computer screen, the medical record of Resident 277. Information displayed on the screen included, but was not limited to, the resident's name, date of birth, room number, and photograph. One independently mobile resident and 2 visitors were observed to walk by the computer during that time. Interview, on 6/26/19 at 2:15 P.M., The Director of Nursing indicated the computers were not to be left unattended, when displaying resident personal and medical information, in order to protect resident confidentiality. On 6/26/19 at 2:50 P.M., the Director of Nursing provided the "Resident Rights," effective date, 11/30/17, and indicated these were the resident rights currently used by the facility. A review of the "Resident Rights" indicated, "...the resident has the right to personal privacy and confidentiality of his or her personal and medical records..." 3.1-3(o)		confidentiality of records. The display of any public resident records was immediately removed and secured throughout. All licensed nursing staff have been educated on resident record privacy including the securing of unattended computer electronic records and/or similar devices. Unit Manager(s) will conduct privacy security audits regarding the above M-F. The same will be conducted by the Weekend Supervisor Sat.-Sun. Any violations of the above will be swiftly addressed at the point of non-compliance. The above will be conducted daily for four (4) consecutive weeks. The same will then be conducted 3x's/week - for four (4) consecutive weeks. Lastly, the practice will be manifest weekly for four (4) consecutive weeks. Throughout, the same will be monitored by the QAPI body for three (3) consecutive months to determine compliance and the need for future monitoring and/or programmatic derivation.	
F 0600 SS=G	483.12(a)(1) Free from Abuse and Neglect			

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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure a resident was free from abuse by another resident (Resident 326) which resulted in multiple skin tears, multiple bruises, and a hematoma for 1 of 1 resident reviewed for abuse (Resident 69). Findings include: Interview, on 6/25/19 at 10:37 a.m., Resident 69's wife indicated she had received a phone call on, 6/23/19 at 3:58 a.m., that Resident 69 had been "assaulted" by another resident (Resident 326). The other resident had hit Resident 69 with his walker and fist. During the interview, Resident 69 was observed to have a baseball-size purple bruise on the left side of his chin; multiple bruises on his bilateral arms; hematoma (localized swelling that is filled with blood) above his right eye; and a white dressing to his left upper arm. Resident 69's wife indicated he had a skin tear with a bruise to the left upper arm and had a skin tear and bruise to the right great toe.	F 0600	The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction: F600 - It shall be the practice of Golden Living (of Bloomington) to insure all residents are free from abusive and neglective practices and/or environments. Neither resident alleged to have been abused or neglected are currently in residence at Golden Living (of Bloomington). All patients have the potential to be affect by the alleged deficient practice. The behavior monitoring records for the past 30 days were reviewed to identify any patient with increased behaviors.	07/31/2019

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	Interview on, 6/25/19 at 3:43 p.m., Registered Nurse (RN) 1 indicated Resident 69's roommate came up to the nurses station and informed her there was a fight in his room. Resident 69 was in front of his TV. Resident 69 and Resident 326 were having a "tugging war" with Resident 69's walker. Resident 326 wanted Resident 69 out of "his house." Resident 326 was assisted to his room and placed on 15 minute checks at that time. Resident 69 was assessed with bruises and skin tears, and was sent out to the ER. On 6/25/19 at 2:10 p.m., Resident 326's clinical was reviewed. Diagnosis included, but were not limited to, mental disorder, dementia with behaviors, and anxiety disorder. His admission date was 6/21/19. Resident 326's admission Clinical Health Status Assessment, dated 6/21/19, indicated he had short term and long term memory problems; had a history of wandering; had a history of socially inappropriate and disruptive behaviors, resisted care, and he could ambulate and transfer himself independently. Resident 326 had increased signs and symptoms of anxiety, exit seeking, and wandering behaviors upon admission. He was difficult to redirect. When able to redirect, redirection was effective for short periods. Resident 326's progress notes indicated the following: -On 6/21/19 at 6:36 p.m., Resident 326's received a new order for Xanax (medication for anxiety) 0.25 milligrams (mg) twice a day for 3 days for anxiety. -On 6/21/19 at 7:01 p.m., Resident 326 was admitted to the facility at approximately 3:45 p.m. Resident 326 had been exit seeking since arrival, banged on the doors, and made threats to break		The IDT will review nurses notes and Point of Care (POC) documentation daily to identify increased patient behaviors. Identified patients will be referred to *Green House Mental Health Services.* All nursing staff have been educated in reference to the proper and immediate notification of the Director of Nursing Services (or designee) as it may apply of aggressive resident behavior/interventions. Effective interventions may include close 1:1 staff-to-resident observation and supervision. The QAPI Committee will review the monthly behavior committee notes to ensure identified behaviors are being addressed/referred to *Green House Mental Health Services* monthly x 3 months. The QAPI Committee will determine if monitoring needs to be continued by the QAPI Committee or may continue to be monitored on-going through the monthly Behavior Committee based on the monthly audits.	

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	the glass to get out. He was aggressive towards staff and raised his fist several times. He was redirected to watch TV and snacks were accepted. -On 6/22/19 at 12:27 p.m., Resident 326 yelled at staff and raised his fist. He threatened to "shoot all of you if you don't get out of my house." He was ambulating through the hallway with a cup in his hand, banged on residents' doors, and threw other residents' clothing on the floor. Resident 326 was not compliant with redirection at that time. The on-call physician was notified and gave a new order to send Resident 326 to the ER (emergency room) for evaluation and treatment. -On 6/22/19 at 3:23 p.m., Resident 326 returned from the ER with new orders to stop Xanax and start buspirone (medication to treat anxiety) 5 mg three times a day. -On 6/22/19 at 6:40 p.m., the Nurse Practitioner (NP) indicated to continue Xanax 0.25 mg twice a day and buspirone. On 6/22/19 at 8:56 p.m., Resident 326 was exit seeking and said he would break down the doors or windows. He was said "I'm not staying here tonight," "I'm done," "I want to go home," "I'll call the sheriff and attorney." He was attempted to be redirected. -On 6/22/19 at 9:58 p.m., Resident 326 was very agitated throughout the evening. He was exit seeking and had to be redirected multiple times throughout the evening. He used profanity while speaking to staff and others. -On 6/22/19 at 10:28 p.m., Resident 326 used the bathroom in the woman's bathroom across the hall. He was upset because a female resident			

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	attempted to use the woman's bathroom. The nurse attempted to assist Resident 326 back to his room. He was noncompliant. He used profanity and yelled. He was combative with staff. He threatened to hit staff and residents. The attempts to redirect were not successful. The staff tried to explain the bathroom was for women only. He refused to comply and continued to be aggressive and threatened the staff. Resident 326 slammed the door several times and punched the wall several times. -On 6/22/19 at 10:42 p.m., Resident 326 continued with the profanity in his room. -On 6/23/19 at 2:30 a.m., Resident 69's roommate called the nurse into his room. When the nurse entered the room, Resident 326 and Resident 69 were standing in front of the TV holding onto Resident 69's walker. Resident 69 was holding onto the legs of the walker and Resident 326 was holding onto the top of the walker. Resident 326 indicated this was his house and to get out. The nurse intervened and redirected Resident 326 back to his room. -On 6/23/19 at 3:10 a.m., the on-call physician was notified and a new order was received to send Resident 326 to the ER for evaluation and treat. While the police were talking with Resident 326, he began hitting a police officer with a closed fist. The staff and officer attempted to redirect Resident 326 without success. An ambulance arrived at that time. Resident 326 refused to go to the ER. Resident 326 cursed and swung at the Emergency Medical Technician (EMT) and police officer. Resident 326 was given sedation by the EMT staff. Resident 326 continued to curse and swing at staff. The EMT placed Resident 326 in wrist restraints and left the facility to transport			

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him to the ER.

-On 6/23/19 at 5:30 a.m., Resident 326 was admitted to psychiatric unit.

On 6/25/19 at 2:00 p.m., Resident 69's clinical record was reviewed. Diagnosis included, but were not limited to, dementia with behaviors and psychotic disorder.

The annual Minimum Data Set (MDS) assessment, dated 5/14/19, indicated Resident 69 had severe cognitive impairment.

Resident 69's progress notes indicated the following:

-On 6/23/19 at 2:30 a.m., Resident 69's roommate called the nurse into his room. When the nurse entered the room, Resident 69 and Resident 326 were standing in front of the television holding onto Resident 69's walker. Resident 69 was holding onto the legs of the walker and Resident 326 was holding onto the top of the walker. Resident 326 indicated this was his house and to get out. The nurse intervened and redirected Resident 326 back to his room. The nurse went to check on Resident 69 and noted red drainage on the floor beginning at the bathroom and leading to where Resident 69 was seated, with his sock off, in his recliner. Resident 69's glasses were on his bed and broken. Resident 69 had a skin tear to his first toe on the right foot, a bruise to his abdomen, a bruise to his chin line, a bruise to the back of his right hand, a bruise and skin tear to his left arm, and an abrasion to his lip.

-On 6/23/19 at 3:10 a.m., the nurse received a new order to send Resident 69 to the emergency room (ER) for an evaluation and treatment.

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-On 6/23/19 at 4:34 a.m., Resident 69's wife was at the facility. Resident 69 left via the ambulance to the ER.

-On 6/23/19 at 10:00 a.m., Resident 69 returned from the ER. Skin assessment was completed. Resident 69 had multiple bruises, a hematoma to the forehead, and 3 skin tears.

Interview on, 6/25/19 at 2:10 p.m., the Director of Nursing (DON) indicated Resident 326 was an emergency admit from home on 6/21/19. After Resident 326 was admitted to the facility, he became anxious and wanted to go home. The NP (nurse practitioner) was still at the facility on the evening Resident 326 was admitted and ordered Xanax for 3 days to help him adjust to the new facility. On the morning of 6/22/19, Resident 326 was having behaviors and was sent to the ER. He returned from the ER with medication changes.

Interview, on 6/25/19 at 3:38 p.m., Certified Nursing Assistant (CNA) 1 indicated around lunch, on 6/22/19, Resident 326 was upset because family members were visiting with another resident. Resident was upset and was arguing with the family because he thought "all these people were in his house." Resident 326 was physically abusive with care. CNA 1 had been provided direction to, "keep a close eye on" Resident 326.

On 6/26/19 at 2:51 p.m., the DON provided the facility's policy, Investigation and Reporting of Alleged Violations of Federal and State Laws... Abuse...," and indicated the policy was current. A review of the policy indicated, "...It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse...Abuse is the

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	willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish...Physical abuse includes hitting, slapping, punching and kicking..." 3.1-27(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a suprapubic catheter (a tube inserted into the bladder through a small hole in the abdomen and drains urine from the bladder) and a Foley catheter (flexible tube which passed through the urethra and into the bladder to drain urine) drainage bag were positioned off of the floor for 2 of 4 residents reviewed for urinary catheter use. (Resident 65 and Resident 124) Findings include: 1. On 6/27/19 from 2:40 p.m. to 2:45 p.m., Resident 65's catheter drainage bag was observed on the ground below the bed. Interview, at that time, the resident indicated, "I have a UTI [urinary tract infection]." On 6/28/19 from 9:54 a.m. to 10:00 a.m., a corner of the Resident 65's catheter drainage bag was observed resting on the ground, below the bed. On 7/1/19 at 10:14 a.m., Resident 65's catheter drainage bag was observed resting the on ground below the bed. Interview, at that time, CNA 2 indicated the catheter drainage bag should be in a cover and not on the ground. Resident 65's clinical record was reviewed, on 6/28/19 at 11:00 a.m. Diagnoses included, but were not limited to: quadriplegia (paralysis of the arms and legs), neuropathic bladder (when the bladder does not empty or store urine properly due to a neurological condition or spinal cord injury), and	F 0690	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** F690 - **It shall be the policy of Golden Living (of Bloomington) to insure all residents who require continence of bowel and/or bladder interventions do so according to all regulatory parameters and requirements.** Any alleged failed bowel and/or bladder intervention(s) have been removed. This includes insuring all catheter drainage devices are appropriately secured above ground level and according to approved practice standards. All licensed nursing staff have been educated on appropriate bowel/bladder interventions and strategies as it may pertain to catheter drainage device placement and security. All nursing TAR records have been updated to include catheter drainage device review and monitoring - each shift. Unit Manager(s) will conduct compliance audits regarding the above M-F. The same will be	07/31/2019

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	urinary tract infection. Resident 65's current, July, 2019, physician orders indicated: "... Suprapubic Cath [catheter]: check for proper placement/patency. Ensure Suprapubic catheter is secure with leg strap ... Provide privacy bag ..." The order start date was 12/28/17. A care plan, initiated on 12/28/2017, with a revision date of 5/14/19 and current through 8/13/19, for Resident 65 indicated, "FOCUS: ... Alteration in elimination of bowel and bladder, Supra pubic Urinary Catheter ... GOAL: I will have no complications from use of my Supra pubic catheter such as pain, infection, obstruction ... INTERVENTIONS: Keep drainage bag of catheter ... off the floor ..." On 7/1/19 at 12:40 p.m., the Director of Nursing provided the facility's policy,"Catheter (Indwelling, Insertion and Removal of Female and Male)," dated 6/24/18, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 14. Secure urinary drainage bag ... and keep off the floor at all times ..." 2. On 6/26/2019 at 10:14 a.m., Resident 124 was observed to be asleep is her room, with the Foley catheter (F/C) drainage bag having touched the floor. On 6/27/2019 at 2:19 p.m., Resident 124 was observed to be in her wheelchair in her room, with the F/C tubing having touched the floor. Resident 124's clinical record was reviewed on 6/27/2019 at 11:40 a.m. Diagnoses included, but were not limited to: uninhibited neuropathic bladder and retention of urine.		conducted by the Weekend Supervisor Sat.-Sun. Any violations of the above will be swiftly addressed at the point of non-compliance. The above will be conducted daily for four (4) consecutive weeks. The same will then be conducted 3x's/week - for four (4) consecutive weeks. Lastly, the practice will be manifest weekly for four (4) consecutive weeks. Throughout, the same will be monitored by the QAPI body for three (3) consecutive months to determine compliance and the need for future monitoring and/or programmatic derivation.	

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	155278	A. BUILDING 00 B. WING	07/01/2019

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	Physician orders, dated July 2019, indicated "... Place 16 Fr [french] with 10 cc [cubic centimeter] bulb F/C for urinary retention ..." The order start date was 10/7/2018. A care plan, initiated on 5/9/2016, with a revision date of 6/14/2019 and current through 9/17/2019, for Resident 124 indicated: "... FOCUS: Alteration in elimination of bowel and bladder, Indwelling Urinary Catheter ... GOAL: I will have no complications from use of my indwelling catheter such as pain, infection, obstruction ... INTERVENTIONS: Keep drainage bag of catheter ... off the floor ..." Interview, on 6/28/2019 at 11:05 a.m., Licensed Practical Nurse (LPN) 1 indicated Resident 124's F/C drainage bag and tubing should not touch the floor. On 7/1//2019 at 12:40 p.m., the Director of Nursing provided the facility's policy,"Catheter (Indwelling, Insertion and Removal of Female and Male)," dated 6/24/2018, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 14. Secure urinary drainage bag ... and keep off the floor at all times ..." The policy did not address keeping the F/C drainage bag in a dignity bag. 3.1-41(a)(2)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides-			

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	§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to provide food that was palatable for 6 of 130 residents who reside at the nursing facility (Resident 7, 65, 106, 60, 16, and 61). Findings include: Interview, on 6/25/19 at 12:03 p.m., Resident 7 indicated, "Food is not good. They do not know how to cook the vegetables. They are either undercooked or overcooked." Interview, on 6/26/19 at 2:49 p.m., Resident 65 indicated, "The food is terrible." Interview, on 6/26/19 at 3:32 p.m., Resident 106 indicated, "The food is terrible and we never have fresh fruits and veggies." On 6/28/19 at 11:45 a.m., a lunch test tray was obtained. The menu included, but was not limited to: breaded fish, french fries, green beans, and Ambrosia Salad (a fruit dessert). The fish and french fries were observed to be tough to cut or be chewed. The ambrosia salad smelled of a unpleasing, strong, sour odor. Random interviews were conducted on 6/28/10 at 12:30 p.m., after residents had eaten lunch. -Resident 50 was observed to struggle while cutting up the fish and indicated, "Needs more fish. It's tough."	F 0804	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction**: F804- The Facility will provide food prepared by methods that conserve nutrient value, flavor, and appearance; and food and drink that is palatable, attractive and at a safe and appetizing temperature. Facility was not notified of resident concerns until the 2567 report was received. Those residents who could be identified from the 2567 report were interviewed. Food preferences and food palatability were reviewed with corrective action taken as needed. That said, alternatives (or substitutions) are currently available for foods identified as “dislikes” at each meal. The *Food Committee* will meet to determine food palatability and future alternative (or substitution) selecting methodologies. All residents (that eat by mouth) have the potential to be affected by the reported deficient practice. To intervene, all dietary staff will be in-serviced/educated by on	07/31/2019

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	-Resident 16 was observed to struggle while pulling apart the fish by hand and indicated, "It's tough." -Resident 61 indicated, "The fries and fish are ok for being made of concrete." Interview, on 6/28/19 at 11:58 a.m., the Administrator was observed to cut the fish with a fork and indicated "it was tough" and "we can do better." Interview, on 6/28/19 at 12:05 p.m., the Dietary Manager indicated the residents like the fish to be crispy, however, the fries and fish were hard to cut with a fork. The Ambrosia Salad included sour cream versus whipped topping, oranges, pineapple, and coconut. 3.1-21(a)(2)		*food palatability*. At the same time, all dietary staff will be in-serviced/educated on *fish & vegetable cookery*. Throughout, at least three (3) residents - at a predetermined meal - will be interviewed for palatability daily five (5) times per week for four (4) weeks. Following three (3) times a week for an additional four (4) weeks. Then one (1) time a week for an additional four (4) weeks. Total of 12 weeks. The *Food Committee* will support by convening one (1) time per week for four (4) consecutive weeks to provide input on food palatability. Assuming resolution, The *Food Committee* will then resume a monthly schedule. Success trending will be monitored by ED/RD (or designee) with a prepared test tray at least one (1) time a week for 12 consecutive weeks. Lastly, the Dietary Manager (CDM)/designee will report any deficient patterns or trends to the QAPI body for three (3) consecutive months to determine programmatic resolution or lack thereof.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,			

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	sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure comfortable sound levels were maintained (Resident 70) and failed to ensure a feeding pump and pole were kept (Resident 97) clean for 2 of 32 residents reviewed for environment. Findings include: 1.) On 6/25/19 from 10:08 A.M. to 10:10 A.M., a loud, high pitched, squealing sound was heard emitting from the room of Resident 70. During observation, on 6/25/19 at 10:10 A.M., the sound was emitting from a contact alarm (an alarm by which 2 parts are in contact until separated, at which time an alarm sounds). The alarm was placed on the resident room's bathroom door and designed to sound when the door was opened. Resident 70 was observed lying in her bed, which was the bed closest to the bathroom door alarm. The alarm was observed to sound during the following dates and times, emitting a loud, high pitched, squealing sound: - 6/26/19 from 11:20 A.M. to 11:21 A.M. and 11:45 A.M. to 11:46 A.M. - 6/27/19 from 11:09 A.M. to 11:10 A.M., 2:53 P.M. to 2:55 P.M., 3:15 P.M. to 3:16 P.M., and 3:24 P.M. to 3:25 P.M. Interview, on 6/26/19 at 11:50 P.M.: Resident 70 indicated the bathroom door alarm sounds every time her roommate opens the bathroom door. The sound was loud, high pitched, squealing, and disturbed her, keeping her from getting consistent	F 0921	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **F921** **It shall be the policy of Golden Living (of Bloomington) to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.** The alleged excessive audible alarm device has been removed from practice. Similarly, the single feeding pump support device has been cleaned to practice standard. All licensed nursing staff have been educated regarding environmental cleaning/sanitation standards of feeding pump support devices. All nursing TAR records have been updated to include nightly feeding pump support devices review and cleaning. Unit Manager(s) will conduct compliance audits regarding the above M-F. The same will be conducted by the Weekend Supervisor Sat.-Sun. Any violations of the above will be addressed at the point of non-compliance The above will be conducted daily for four (4) consecutive weeks. The same will then be conducted	07/31/2019

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	rest. She wished if there had to be an alarm on the door it could have been a more pleasant sound and not so loud. Interview, on 7/1/19 at 11:00 A.M.: The Director of Nursing indicated the bathroom alarm was loud and could have been disruptive to the resident. Interview, on 7/1/19 at 11:30 A.M.: The Maintenance Director indicated the alarm was loud and shrill. 2.) On 6/26/19 at 3:41 P.M., Resident 97's feeding pump and pole were observed at the resident's bedside. On both the pump and pole was a dried tan colored substance in a dripping pattern. On the following dates and times, the feeding pump and pole were found at the resident's bedside with the same dried tan colored substance in the same dripping pattern: - 6/27/19 at 2:40 P.M. - 6/28/19 at 10:00 A.M. - 6/29/19 at 2:30 P.M. During an interview, on 7/1/19 at 11:00 A.M., the Director of Nursing indicated the feeding pump and pole were to be cleaned after use and not to be left stained. On 6/26/19 at 2:50 P.M., the Director of Nursing provided the "Resident Rights," effective date, 11/30/17, and indicated these were the resident rights currently used by the facility. A review of the "Resident Rights" indicated, "....the resident has the right to...a clean, comfortable, homelike environment..." 3.1-19(f)(5)		3x's/week - for four (4) consecutive weeks. Lastly, the practice will be manifest weekly for four (4) consecutive weeks. Throughout, the same will be monitored by the QAPI body for three (3) consecutive months to determine compliance and the need for future monitoring and/or programmatic derivation.	

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