STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	07/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00297934. Complaint IN00297934 - Substantiated. Federal/state deficiencies related to the allegations are cited at F656 and F842. Survey date: July 8, 2019 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 7 Medicaid: 53 Other: 5 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 12, 2019	F 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute and admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors" findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Golden living Centers Richmond respectfully requests paper compliance to coincide with this Plan of Correction.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to develop a care plan to address the bathing and hygiene needs and preferences for 2 of 3 residents reviewed for bathing and hygiene.	F 0656	F656 Comprehensive Care Plans 1.) Resident A and B care plans were revised to reflect resident preferences and assistance	08/07/2019

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	(Residents B and C) Findings include: A. The clinical record of Resident B was reviewed on 7-8-19 at 10:50 a.m. Her diagnoses included, but were not limited to, osteoarthritis of the right shoulder and knees, general muscle weakness and chronic pain. Her most recent Minimum Data Set (MDS) assessment, dated 5-25-19, indicated she is cognitively intact, is non-ambulatory, requires a wheelchair for mobility, requires extensive assistance of two or more persons with hygiene care and is dependent of two or more persons for bathing care. In review of Resident B's care plans for activities of daily living (ADL's), a care plan, dated 12-15-17, and revised on 6-25-18, indicated "a physical functioning deficit related to: non-ambulatory, decreased mobility, functional limitation with ROM [range of motion]" failed to address the bathing and hygiene care needs for Resident B. In an interview with Resident B on 7-8-19 at 11:15 a.m., she indicated she requires assistance from facility staff with showers twice weekly and hygiene services on non-shower days. In an interview with the Director of Nursing (DON) on 7-8-19 at 4:25 p.m., she indicated the MDS staff have been "kind of been behind and I will make sure that MDS and nursing start adding something in the care plans about the bathing and hygiene and what help the resident needs with that. As for expectations for care plans, they need to be written for the initial care plans within the first 48 hours, then reviewed or added to quarterly, with any change in condition, with any significant change and annually."		needed with showering/hygiene. 2.) Facility to audit all other residents to reflect current needs of assistance and preferences with hygiene/showering. 3.) DNS or designee to in-service nursing staff on updating care plans to reflect resident current needs pertaining to assistance needed/preferences with hygiene/showering. DNS educated MDS on changing or updating care plans with significant changes, quarterly, and annual clinical health status assessments (CHS). 4.) DNS or designee to audit resident care plans for an initial review. Audits will then be done daily on residents with significant changes, quarterly, or annual CHS assessment and all residents with care conferences that week for proper preferences and assistance needed with showering/hygiene 5 x a week x 2 weeks, 3 times a week x 4 weeks, 2 x a week x 4 weeks and 1x a week x 4 weeks. Audits will be reviewed in QAPI for 6 months or until 100% compliance achieved. 5.) To be completed by August 7, 2019	

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	B. The clinical record of Resident C was reviewed on 7-8-19 at 1:04 p.m. Her diagnoses included, but were not limited to, unspecified encephalopathy, chronic intractable headache, unspecified osteoarthritis, anxiety, chronic pain, cognitive communication deficit, difficulty in walking, right knee pain and late onset Alzheimer's disease. Her most recent Minimum Data Set (MDS) assessment, dated 4-18-19, indicated she is moderately cognitively impaired, is able to walk with the supervision of one person and requires extensive assistance of one person with both bathing and hygiene. In an interview with the Director of Nursing (DON) on 7-8-19 at 4:25 p.m., she indicated Resident C "has begun to need more assistance with her ADL's [activities of daily living]. I'm not sure if it's because of her aging or related to her dementia or both." In review of Resident C's care plans for ADL's, a care plan, dated 4-18-17 and revised on 6-18-18, indicated "a physical functioning deficit related to: mobility impairment, self care impairment due to AMS [altered mental status] and Alzheimer's disease and shortness of breath r/t dx [related to a diagnosis of]: emphysema," failed to address the bathing and hygiene care needs for Resident C. In an interview with the DON on 7-8-19 at 4:25 p.m., she indicated the MDS staff have been "kind of been behind and I will make sure that MDS and nursing start adding something in the care plans about the bathing and hygiene and what help the resident needs with that. As for expectations for care plans, they need to be written for the initial care plans within the first 48 hours, then reviewed or added to quarterly, with any change in			

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	condition, with any significant change and annually." This Federal tag relates to Complaint IN00297934. 3.1-35(a) 3.1-35(b)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care			

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	operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure the documentation of bathing and	F 0842	F842 Resident Identifiable Information	08/07/2019

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	hygiene was accurately documented on both hand-written shower sheets, as well as computer documentation for 3 of 3 residents reviewed for bathing and hygiene. (Residents B, C, and D) Findings include: A. The clinical record of Resident B was reviewed on 7-8-19 at 10:50 a.m. Her diagnoses included, but were not limited to, osteoarthritis of the right shoulder and knees, general muscle weakness and chronic pain. Her most recent Minimum Data Set (MDS) assessment, dated 5-25-19, indicated she is cognitively intact, is non-ambulatory, requires a wheelchair for mobility, requires extensive assistance of two or more persons with hygiene care and is dependent of two or more persons for bathing care. On 7-8-19 at 3:50 p.m., the Director of Nursing (DON) provided a weekly shower calendar to indicate Resident B was to receive twice weekly showers on Mondays and Thursdays. Review of the hand-written shower sheets, used to document when a shower was provided to the resident, indicated Resident B received a shower on 6-6-19, 6-10-19, 6-13-19, 6-17-19, 6-25-19, 6-27-19, 7-1-19 and 7-4-19. It indicated on 6-20-19, Resident B had declined a shower. Review of a computer-generated "Showering," form indicated Resident B had received a "s," depicted as a shower on the form's legend, on 6-13-19, 6-27-19, 6-28-19 and 7-4-19. This form indicated the resident received a "FB," which was not listed on the form's legend, on 6-2-19, 6-3-19, 6-5-19, 6-6-19, 6-7-19, 6-8-19, 6-10-19, 6-11-19, 6-14-19, 6-19-19, 7-5-19 and 7-8-19.		1.) Residents B, C, D preference sheets were reviewed with each resident to clarify showering preferences, ADL sheets were reviewed for needed updates with hygiene/showering needs. 2.) Facility interviewed residents for accuracy with preference sheets, assigned shower days, updated ADL sheets and revised all as needed. 3.) DNS in-serviced staff on proper documentation of shower sheets and computerized charting regarding showering/hygiene preferences and assistance needs. 4.) DNS or designee to audit residents to receive shower the following day to verify shower sheet and computerized charting are accurate 5x week 2 weeks, 3 x a week for 4 weeks, 2 x weekly for 4 weeks, and 1x week 4 weeks. Audits will be reviewed in QAPI for 6 months or until 100% compliance. 5.) To be completed by August 7, 2019	

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	In interview with the DON on 7-8-19 at 4:20 p.m., she indicated she assumed the "FB" referred to provision of a full or complete bed bath, but was not certain of the exact meaning. In an interview with the DON on 7-8-19 at 4:25 p.m., she indicated the facility has several fairly new CNA's, "and they seem to be having some trouble with charting the ADL's [activities of daily living], like the bathing and hygiene, in the computer. As you can see from the documentation, it doesn't always match what the shower sheets say. We need to get better at that. Looks like we need to do more training on that. And, for the shower sheets and the [name of specific program] computer documentation, they should match. Shower sheets should be filled out by the CNA's any time a shower is done or refused and turned into the charge nurse to review and sign." On 7-8-19 at 5:05 p.m., the DON provided a summary of an inservice education form which indicated facility staff were educated on 4-2-19 on the topic of the facility's computer documentation system, specific to "shower documentation." B. The clinical record of Resident C was reviewed on 7-8-19 at 1:04 p.m. Her diagnoses included, but were not limited to, unspecified encephalopathy, chronic intractable headache, unspecified osteoarthritis, anxiety, chronic pain, cognitive communication deficit, difficulty in walking, right knee pain and late onset Alzheimer's disease. Her most recent Minimum Data Set (MDS) assessment, dated 4-18-19, indicated she is moderately cognitively impaired, is able to walk with the supervision of one person and requires			

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extensive assistance of one person with both bathing and hygiene.

On 7-8-19 at 3:50 p.m., the Director of Nursing (DON) provided a weekly shower calendar to indicate Resident C was to receive twice weekly showers on Mondays and Thursdays.

Review of the hand-written shower sheets, used to document when a shower was provided to the resident, indicated Resident C received a shower on 6-6-19, 6-29-19 and 7-5-19. It indicated on 6-13-19, 6-20-19 and 7-4-19, Resident C had declined to receive a shower.

Review of a computer-generated "Showering," form indicated Resident C had received a "s," depicted as a shower on the form's legend, on 6-16-19, 6-29-19 and 7-2-19. It indicated Resident C had refused a shower, as depicted by an "RR," on the form's legend, on 6-15-19, 6-22-19, 6-25-19, 6-27-19, 6-28-19 and 7-4-19.

In an interview with the DON on 7-8-19 at 4:25 p.m., she indicated the facility has several fairly new CNA's, "and they seem to be having some trouble with charting the ADL's [activities of daily living], like the bathing and hygiene, in the computer. As you can see from the documentation, it doesn't always match what the shower sheets say. We need to get better at that. Looks like we need to do more training on that. And, for the shower sheets and the [name of specific program] computer documentation, they should match. Shower sheets should be filled out by the CNA's any time a shower is done or refused and turned into the charge nurse to review and sign."

On 7-8-19 at 5:05 p.m., the DON provided a

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	summary of an inservice education form which indicated facility staff were educated on 4-2-19 on the topic of the facility's computer documentation system, specific to "shower documentation." C. The clinical record of Resident D was reviewed on 7-8-19 at 1:56 p.m. His diagnoses included, but were not limited to, high blood pressure, anemia, unspecified shoulder pain and abnormal gait & mobility. His most recent Minimum Data Set (MDS) assessment, dated 6-7-19, indicated he is cognitively intact, is able to walk independently in his room and requires supervision of one person with both bathing and hygiene. In an interview with Resident D on 7-8-19 at 11:08 a.m., he indicated he prefers to shower only on Thursdays and requires staff assistance with showering. On 7-8-19 at 3:50 p.m., the Director of Nursing (DON) provided a weekly shower calendar to indicate Resident D was to receive once weekly showers on Thursdays. Review of the hand-written shower sheets, used to document when a shower was provided to the resident, indicated Resident D received a shower on 6-5-19, 6-13-19, 6-27-19 and 7-4-19 . The hand-written shower sheets did not reflect any resident refusals of showers for Resident D for the time period of 6-1-19 to 7-8-19. Review of a computer-generated "Showering," form indicated Resident D had received a "s," depicted as a shower on the form's legend, on 6-5-19, 6-13-19, 6-20-19, 6-27-19 and 7-4-19. It indicated Resident D had refused a shower, as depicted by an "RR," on the form's legend, on 6-3-19, 6-4-19 and 6-26-19.			

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	In an interview with the DON on 7-8-19 at 4:25 p.m., she indicated the facility has several fairly new CNA's, "and they seem to be having some trouble with charting the ADL's [activities of daily living], like the bathing and hygiene, in the computer. As you can see from the documentation, it doesn't always match what the shower sheets say. We need to get better at that. Looks like we need to do more training on that. And, for the shower sheets and the [name of specific program] computer documentation, they should match. Shower sheets should be filled out by the CNA's any time a shower is done or refused and turned into the charge nurse to review and sign." On 7-8-19 at 5:05 p.m., the DON provided a summary of an inservice education form which indicated facility staff were educated on 4-2-19 on the topic of the facility's computer documentation system, specific to "shower documentation." This Federal tag relates to Complaint IN00297934. 3.1-50(a)(1) 3.1-50(a)(2)			