STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 00 B. WING	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	800 E OHIO ST JASONVILLE, IN 47438

(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 a Recertification and State Licensure Survey. Survey dates: November 14, 15, 16, 17, and 18, 2022 Facility number: 000200 Provider number: 155303 AIM number: 100367980 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 2 Medicaid: 26 Other: 4 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 22, 2022.	F 0000	*December 9, 2022* *To : Long Term Care Director* *Attention Brenda Buroker* *Indiana State Department of Health* *2 North Meridian Street, Indianapolis, IN 46204* *Re: Good Samaritan Society Shakamak Retirement Comm* *CCN/Provider Number: 155303* *AIM Number: 100367980* *Facility ID: 000200* *This letter comes to you as a request for paper compliance to the facility's Recertification and State Licensure Survey dated November 14th through November 18th 2022.* *The facility received 2 deficiencies which were low scope and severity in nature* *The facility feels it has corrected the deficiencies and submits to the department the following proof of corrections.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah E Davis	HFA	12/09/2022

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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			Please see the uploaded corrections. *Sincerely,* *Deborah E Davis, Health Facility Administrator* *812-665-2226*	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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 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.			

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	(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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure staff implemented a fall care plan intervention for a resident with a history of falls for 1 of 2 residents reviewed for accidents.(Resident 15) Findings include: On 11/17/22 at 10:55 a.m., Resident 15 was observed sitting in bed wearing a long oxygen tube connected to the oxygen concentrator at her bedside. The tubing was approximately 20 feet long and was tangled underneath her bed and walker. The resident stated how the floor was very slippery and demonstrated how her feet slipped with her slippers on by sliding her feet back and forth while sitting upright in her bed. On 11/18/22 at 11:48 a.m., Resident 15 was observed in bed shuffling her oxygen tubing around in an attempt to detangle the long tube.	F 0656	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.	12/09/2022

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	On 11/17/22 at 2:29 p.m., Resident 15's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic respiratory failure, difficulty in walking, heart failure, muscle weakness, and unsteadiness on feet. A review of Resident 15's care plans indicated a fall care plan, revised on 9/15/22 with a target dated of 2/15/23, had a fall intervention for staff to ensure oxygen tubing was shortened. On 11/17/22 at 2:58 p.m., the DON indicated that hospice staff were responsible for changing the oxygen tubing. She indicated she was not aware of the resident being care planned for needing short oxygen tubing. On 11/18/22 at 2:30 p.m., the DON provided the facility policy, "Fall Prevention And Management-Rehab/Skilled Therapy & Rehab," revised on 3/30/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...[post fall] 18. Continue to monitor condition and the effectiveness of the interventions..." 3.1-35(g)(2)		**F 656** **Develop/Implement Comprehensive Care Plans (D)** Element 1 Resident 15 does not reside in this facility at this time, however the care plan for resident 15 was reviewed and updated by the DON to reflect appropriate interventions for fall prevention before the resident was discharged on 12/2/22. Element 2 Residents who sustain a fall have the potential to be affected by this alleged deficient practice. On 11.21.22, the Nurse Educator created a resource binder containing the policy Fall Prevention and Management – Rehab/Skilled, instructions for how to create an incident report, and packets containing the fall scene huddle worksheet (root cause analysis) with instructions and witness statement was placed in a prominent location in the nursing station. Director of Nursing and Nurse Educator huddled with licensed nurses to educate regarding the location, use of the fall resource binder, and a reminder to always update the care plan with an immediate intervention to prevent the recurrence of falls.	

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			Element 3 Systemic change will occur to ensure that following a resident's fall the proper process for root cause analysis and update of the care plan are completed for the prevention of fall reoccurrence. The policy Fall Prevention and Management – Rehab/Skilled will be reviewed by the DON. The DON or designee will provide nursing staff, to include the MDS Coordinator, with education sessions related to the fall policy and specific process that must be carried out when a resident experiences a fall, how to update the care plan in the electronic health record and the importance of monitoring the effectiveness of the interventions that put into place. Element 4 The Director of Nursing or designee will conduct weekly audits for 4 weeks, then monthly audits for 3 months. The Director of Nursing or designee will present weekly and monthly audits during QAPI meetings for 3 months or until substantial compliance is sustained. Element 5 Date of Compliance: 12/9/2022	
F 0695 SS=E	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with professional standards and the plan of care for 5 of 6 residents reviewed. Oxygen was not administered and oxygen tubing was not labeled and dated. (Resident 15, Resident 189, Resident 2, Resident 23, Resident 26) Findings include: 1. On the following dates and times, Resident 15 was observed in bed with oxygen being delivered through tubing which was not labeled and dated: - 11/14/22 at 11:10 A.M. - 11/15/22 at 10:55 A.M. - 11/17/22 at 2:10 P.M. On 11/15/22 at 2:00 P.M., Resident 15's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure and muscle weakness. A physician's order with a start date of 8/27/22 indicated the resident was to receive continuous oxygen through a nasal cannula. 2. On the following dates and times, Resident 2 was observed in bed with oxygen being delivered	F 0695	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. **F 695** **Respiratory/Tracheostomy Care and Suctioning (E)** Element 1 Residents 15, 2, 189, 23, 26 oxygen tubing was immediately changed labeled with staff initials	12/09/2022

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	through tubing which was not labeled and dated: - 11/14/22 at 11:20 A.M. - 11/15/22 at 11:00 A.M. - 11/17/22 at 2:15 P.M. On 11/16/22 at 10:05 A.M., Resident 2 was observed lying in bed asleep with no oxygen nasal cannula (N/C) in his nostrils. The oxygen tubing was rolled up and sitting on the oxygen tank. On 11/16/22 at 10:06 A.M., Licensed Practical Nurse (LPN) 1 and Registered Nurse (RN) 2 were notified that Resident 2 was not wearing oxygen. LPN 1 and RN 1 were observed to immediately enter the room. Resident 2's oxygen saturation was 90% on room air. LPN 1 put the N/C in Resident 2's nostrils. After a few minutes the oxygen saturation was back up to 98%. On 11/16/22 at 10:19 A.M., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to, hypertensive heart disease, chronic kidney disease with heart failure, and dyspnea (shortness of breath). Physician orders, dated 9/18/2022 through 11/18/2022, for Resident 2 indicated, "... Oxygen via nasal cannula 1-4 liters per minute every shift for dyspnea and hypoxia ..." The Quarterly Minimum Data Set (MDS) assessment, dated 9/19/22, indicated Resident 2 was not interviewable and wore oxygen while a resident. A care plan, initiated on 12/28/20, and current through target date 12/26/22, for Resident 2 indicated, "... Focus: The resident is at risk for		and dated on 11/18/2022 as per facility policy. Resident 2 ‘s oxygen was appropriately applied as per physicians’ orders, resident was assessed, and 02 stats were within acceptable guidelines, no labored breathing noted, resident alert and speaking to Nurse 1 and Nurse 2 as per his normal capabilities. Oxygen was re-applied without incident. Staff was re-educated immediately and again starting on 11/21/2022 through 12/6/2022 on the necessity/importance of all appliances to be appropriately applied and present before leaving any resident’s room. Element 2 Residents who have oxygen orders have the potential to be affected by this alleged deficient practice. The facility’s’ policy, Oxygen Administration, Safety, Mask Types- R/S, LTC, Therapy and Rehab revised date of 6/29/22, identifies the Oxygen tubing to be changed weekly and as needed then labeled with staff initials and dated correctly, Nursing staff were re-educated as to the policy starting on 11/21/2022 and was on-going thru 12/6/2022. Staff was re-educated immediately and again starting on 11/21/2022 through 12/6/2022 on the necessity/importance of all appliances to be appropriately	

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	altered cardiovascular status R/T [related to] HHD with HF [hypertensive heart disease with heart failure] ... Oxygen for SOB [shortness of breath] ... Goal: Resident will be free from s/s [signs and symptoms] of complications of cardiac problems through the review date ... Interventions: ... Administer oxygen as ordered ..." During an interview on 11/16/22 at 10:07 a.m., LPN 1 indicated Resident 2 had just been put back to bed after being up for breakfast and the Certified Nursing Assistants (CNA's) forgot to put his oxygen back on. 3. On the following dates and times, Resident 189 was observed in a wheelchair in his room with oxygen being delivered through tubing which was not labeled and dated: - 11/14/22 at 11:30 A.M. - 11/15/22 at 11:05 A.M. - 11/17/22 at 2:20 P.M. On 11/15/22 at 2:10 P.M., Resident 189's clinical record was reviewed. The diagnoses included, but were not limited to, respiratory failure and kidney failure. A physician's order with a start date of 11/15/22 indicated the resident was to receive continuous oxygen through a nasal cannula. 4. On the following dates and times, Resident 23 was observed in bed with oxygen being delivered through tubing which was not labeled and dated: - 11/14/22 at 11:25 A.M. - 11/15/22 at 11:05 A.M. - 11/17/22 at 2:25 P.M.		applied and present before leaving any resident's room Element 3 Systemic change will occur to ensure that residents' oxygen tubing is changed, labeled with initials and dated weekly per facility policy, residents who have orders for oxygen will have oxygen administered per physician orders. The policy Oxygen Administration, Safety, Mask Types- R/S, LTC, Therapy and Rehab will be reviewed by the DON. The DON or designee will provide nursing staff, with education sessions related to Oxygen administration as to applying and re-applying after any transfers, labeling, changing weekly and dating policy. Element 4 The Director of Nursing or designee will conduct audits 3 times weekly for 6 weeks, then weekly for 3 months. The Director of Nursing or designee will present weekly and monthly audits during QAPI meetings monthly or until substantial compliance is sustained. Element 5 Date of Compliance: 12/9/2022	

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	On 11/15/22 at 2:20 P.M., Resident 23's clinical record was reviewed. The diagnoses included, but were not limited to, respiratory failure and depressive episodes. A physician's order with a start date of 10/14/22 indicated the resident was to receive continuous oxygen through a nasal cannula. 5. On the following dates and times, Resident 26 was observed in bed with oxygen being delivered through tubing which was not labeled and dated: - 11/14/22 at 11:35 A.M. - 11/15/22 at 11:10 A.M. - 11/17/22 at 2:30 P.M. On 11/15/22 at 2:30 P.M., Resident 26's clinical record was reviewed. The diagnoses included, but were not limited to, pneumonia and weakness. A physician's order with a start date of 11/22/21 indicated the resident was to receive oxygen through a nasal cannula as needed to maintain oxygen levels at or above 92%. On 11/17/22 at 2:58 P.M., the Director of Nursing indicated the oxygen tubing for Resident 15, Resident 189, Resident 2, Resident 23, and Resident 26 were not labeled and dated. Oxygen tubing was to be changed and labeled with the date it was changed once weekly. On 11/18/22 at 2:30 P.M., the Director of Nursing provided the facility policy, "Oxygen Administration, Safety, Mask Types-R/S, LTC, Therapy and Rehab" with a revised date of 6/29/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, verify physician order, attach nasal			

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	cannula, equipment should be changed weekly and marked with date and initials. 3.1-47(a)(6)			