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	08/14/2020

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00326000, IN00326237, IN00330309, IN00332441, IN00333430 and a COVID-19 Focused Infection Control Survey. Complaint IN00326000- Unsubstantiated, due to lack of evidence. Complaint IN00326237- Unsubstantiated, due to lack of evidence. Complaint IN00330309- Substantiated, Federal/State deficiencies related to the allegations are cited at F-677 and F-686 . Complaint IN00332441- Substantiated, Federal/State deficiencies related to the allegations are cited at F-677 and F-692. Complaint IN00333430- Unsubstantiated, due to lack of evidence. Survey dates: August 10, 11, 12, 13, and 14, 2020 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 8 Medicaid: 42 Other: 5	F 0000		

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 determined that other safegaurds 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.

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	Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on August 24, 2020.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review the facility failed to provide showers for dependent residents for 2 of 3 residents reviewed for Activities Of Daily Living (ADL) (Resident D and G). Findings include: 1. The clinical record for Resident D was reviewed on 8/10/2020 at 2:55 p.m. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, hypertension, Cererbrovascular disease, major depression disorder, osteoporosis and diabetes. The Quarterly Minimum Data (MDS) assessment , dated 5/5/2020, indicated the resident was cognitively impaired for daily decision making. The resident was totally dependent of two physical staff for bathing needs. The resident's preference sheet, dated 11/19/2019, indicated the resident did not prefer to have more then two showers a week. The resident did not prefer a bed bath over a shower.	F 0677	F06700 1. Resident G was discharged home on 6/2/2020. Resident D received a complete bed bath on 8/14/2020 per resident preference. 2. Resident audit completed for all residents dependent for bathing. No further deficient practice found. 3. All Nursing staff educated on resident preference and honoring preference in regard to bathing by Director of Clinical Education or designee. 4. Assistant Director of Nursing or designee will complete 10 resident audits for bathing per preference completed weekly x4 weeks, then 10 residents biweekly x8wks, then 10 residents monthly x2 months. Will review at monthly QAPI meeting for 6 months.	09/13/2020

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	Review of resident's showers for March, April, May June and July 2020, indicated the resident had not received a shower or a complete bed bath for 5 months and had only received partial baths during this time. During an Confidential interview on 8/13/2020 at 2:40 p.m., the facility had changes in management frequently and this caused lack of guidance and consistency for resident care. Resident D had not been provided a shower for several months. 2. The clinical record for Resident G was reviewed on 8/11/2020 at 11:00 a.m. The resident's diagnoses included, but were not limited to, quadriplegia, Respiratory failure, nontraumatic subarachnoid hemorrhage, hypertension, anxiety disorder, pressure induced deep tissue damage of sacral region. The Admission MDS assessment, dated 5/27/2020, indicated the resident was totally dependent of two physical staff for bathing. Review of the resident's shower documentation, dated from 5/20/2020 to 6/2/2020, indicated the resident had not received a shower or full bed bath for the 14 days that he resided at the facility. During an interview with Resident G's family, on 8/13/2020 at 2:45 p.m., they indicated the resident had not had a shower for two weeks while at the facility. When the family picked up the resident from the facility, the resident was unclean and had dirty matted hair. During an interview with the Clinical Education Director on 8/13/2020 at 3:20 p.m., she			

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	indicated the floor nurse should have been ensuring residents were receiving showers. The CNA's would be responsible to to check their shower assignments every day to see which residents were scheduled for showers. The facility was now going to have the Assistant Director of Nursing Services (ADNS) ensure showers were being provided for residents. The bathing policy provided by the Executive Director on 8/14/2020 at 1:30 p.m., indicated the purpose of the policy was to cleanse and refresh the resident, observe the skin and provide increased circulation. This Federal tag relates to Complaints IN00332441 and IN00333039. 3.1-38(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to complete an assessment for a	F 0686	F686 1. Resident G was discharged	09/13/2020

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	deep tissue pressure ulcer and to complete a weekly and accurate skin assessments resulting in the resident acquiring a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident G). Findings include: The clinical record for Resident G was reviewed on 8/11/2020 at 11:00 a.m. The resident's diagnoses included, but were not limited to, quadriplegia, Respiratory failure, nontraumatic subarachnoid hemorrhage, hypertension, anxiety disorder, pressure induced deep tissue damage of sacral region. The Admission Minimum Data Set (MDS) assessment, dated 5/27/2020, indicated the resident required extensive assistance of two physical staff for bed mobility, the resident did not ambulate. The resident was totally dependent of two physical staff for bathing. The resident had an unstageable pressure ulcer and was at risk for developing a pressure ulcer. The wound assessment, dated 5/20/2020, indicated the resident had a suspected deep tissue injury on the coccyx measuring 10 centimeters cm by 10 cm. The pressure ulcer was red/purple in color. The wound assessment, dated 5/23/2020, indicated the resident had a suspected deep tissue injury on the coccyx measuring 10 centimeters cm by 10 cm. The pressure ulcer had no change. There were no further assessments for this wound documented. This indicated the resident went 10 days without a wound assessment. The Physical Therapy plan of care, dated		home on 6/2/2020. 2. Resident's with pressure wounds identified to have the potential to be effected by missed weekly skin evaluations. Audit completed no further deficient practice identified. 3. Nurse education will be provided by Director of Clinical Education or designee regarding completing weekly skin evaluation and completing accurately for all new and existing wounds. 4. ADNS or designee to conduct audits weekly x 4 weeks for completion and accuracy of skin assessments, then biweekly x8 wks, then monthly x2 months. Will review at monthly QAPI for 6 months.	

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	5/20/2020, indicated the resident had a fall at home in February 2020 and sustained a cervical fracture. The resident underwent cervical surgery and spinal fusion. The resident's injury resulted in quadriplegia, and had been using a cervical collar since then. The progress note, dated 6/2/2020 at 10:58 a.m., indicated the resident was being discharged to home with family. The resident's family member removed the resident's cervical collar and his head revealed a stage 2 pressure ulcer on the back of his skull. The pressure ulcer was white and moist. The area measured 2 cm by 2.5 cm. Review of the resident's shower documentation, dated from 5/20/2020 to 6/2/2020, indicated the resident did not receive a shower or full bed bath for the 14 days that he resided at the facility. During an interview, on 8/13/2020 at 12:10 p.m., the Director of Nursing Services (DNS) indicated she was unable to find another wound assessment on the suspected deep tissue injury on the coccyx for Resident G after 5/23/2020. She was unable to find any physician's order, plan of care or documentation related to the care and instructions for the resident's cervical collar. The admitting nurse should have called the hospital and received clarification for care of the cervical collar and if could be removed or not. During an interview, on 8/13/2020 at 2:45 p.m., Resident G's family member indicated the resident's normal routine at home was to shower every other day. The family member indicated during showers the cervical collar was taken off to ensure his skin was intact and he was clean. The facility had not provided showers to the resident or remove the cervical collar for 14			

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	days and the resident acquired a pressure ulcer on his head as a result of this. The bathing policy provided by the Executive Director, on 8/14/2020 at 1:30 p.m., indicated the purpose of the policy included, was not limited to, to observe the skin. The skin integrity policy provided by the Executive Director, on 8/14/2020 at 1:30 p.m., indicated the purpose was to provide a comprehensive approach for monitoring skin conditions and promote healing of wounds. The licensed nurse would be responsible for performing a skin evaluation weekly and document on the wound evaluation flow sheet. The facility would develop a routine schedule to review residents with wounds or at risk on a weekly basis and document findings. CNA's would complete a bath/shower worksheet and turn it into the licensed nurse. If any skin alterations were identified, the licensed nurse would follow up re the skin integrity guideline. This Federal tag relates to Complaint IN00330309. 3.1-40			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to address and implement interventions for a resident's significant weight loss for 1 of 3 resident's reviewed for nutrition (Resident H). Finding include: The clinical record for Resident H was reviewed on 8/12/2020 at 2:50 p.m. The resident's diagnoses included, but were not limited to, dysphasia, diabetes, atrial fibrillation, congestive heart failure, vascular dementia, osteoporosis and depression. The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/2020, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of one physical staff member for eating. The resident's weight was 176 and he had a weight loss of more then 5 % (percent). The resident was not prescribed a weight loss regimen.	F 0692	F692 1. Resident H was added to PAR and weekly weights on 8/12/2020. On 8/14/2020 placed on one-on-one supervision for meals. 2. Audit to be completed to identify residents with significant weight loss for implementation of appropriate interventions. 3. New Dietician started on 7/21/2020. Education to be provided by corporate Registered Dietician to new dietician and dietary manager in regards to monitoring weight loss and appropriate timely interventions. 4. Dietary manager and or designee to audit residents triggering for weight loss for appropriate interventions 5 days weekly during morning clinical meeting x4 wks, then weekly x8 wks, and then monthly x2 wks.	09/13/2020

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	The resident's weights were as follows: - 4/2/2020 the resident weighed 198 pounds - 5/6/2020 the resident weighed 183 pounds The weight loss indicated a 7.58 % weight loss in one month. - 6/3/2020 the resident weighed 175 pounds This indicated a 9.84 % weight loss in one month. - 7/3/2020 the resident weighed 166 pounds This indicated a 5.14% weight loss in one month. - 8/3/2020 the resident weighed 152 pounds This indicated a 8.43 % weight loss in one month. The resident had 16.16 % in three months between 4/2/2020 and 7/3/2020. During an interview, on 8/12/2020 at 2:45 p.m., the Director Of Nursing Services (DNS) indicated she would investigate the residents weight loss since she was unable to find documentation that the facility addressed the weight loss or implemented interventions for the resident's weight loss. During an interview, on 8/13/2020 at 10:40 a.m., the DNS indicated the Interdisplinary Team (IDT) had talked about Resident H's significant weight loss on 8/5/2020, but did not implement any interventions at that time because the resident was on palliative care.		Will review monthly at QAPI meeting x6 months.	

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	The facility had implemented a magic cup for Resident H on 5/20/2020 one time a day and on 8/12/2020 increased it to two times a day. The Registered Dietician (RD) would have been responsible to address the resident's significant weight loss. The facilities RD stopped working at the facility in May 2020. During an interview, on 8/13/2020 at 12:37 p.m., the Dietary Manager indicated the facilities protocol for residents with significant weight loss was the nurse would notify the Dietary Manager of a significant weight loss and the resident would be placed on Patient at Risk (PAR) meeting and supplements and interventions would be implemented. The Dietary Manager indicated she was not notified of Resident H's significant weight loss. During an Confidential interview on 8/13/2020 at 2:40 p.m., the facility staff had not been assisting residents with eating like they needed to be and the facility had not been addressing residents with weight loss. The nutrition policy provided by the Executive Director on 8/14/2020 at 1:30 p.m., indicated "All significant changes, losses as well as gains, must be discussed and interventions determined by all members." "Persistent losses and gains should not be over looked." "Interventions must be implemented to prevent these losses or gains from becoming significant." "The responsibility of this committee is to assure the needs of the resident are met to prevent or stop an undesirable significant change." "The recommended interventions should be tailored to the resident and not "cookie cutter" solutions such as automatic orders for supplements." "The expertise of each team member should be			

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	utilized when developing a plan of care and all are encouraged to find creative interventions." "Once implemented, interventions must be monitored for effectiveness and acceptance by the resident." "If desired results are not obtained the interventions my be changed." It is recommended that monthly significant weight changes of 5 % in one month, 7.5 % in 3 months and 10% in 6 months be documented in the form of an situation-background-recommendation-assessment tool (SBAR) in point click care by nursing staff. This Federal tag relates to Complaint IN00332441. 3.1-46			