

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 IN00319979. Complaint IN00319979 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F744. Survey dates: February 25-27, 2020 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 122 SNF: 11 NF: 25 Residential: 16 Total: 174 Census Payor Type: Medicare: 5 Medicaid: 126 Other: 27 Total: 158 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2020.		F 0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts set forth or the statement of deficiencies. The plan of correction is prepared and submitted to comply with requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. The facility is respectfully requesting desk review for these deficiencies.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident received adequate supervision to prevent falls, for 1 of 3 residents reviewed for falls. (Resident D) Findings include: The closed clinical record of Resident D was reviewed on 2/26/20 at 12:00 P.M. The resident was admitted to the facility on 1/28/20 with diagnoses including, but not limited to, dizziness and giddiness, abnormalities of gait and mobility, and age-related physical debility. An admission baseline care plan, dated 1/28/20, included: "ADL [activities of daily living] Assistance, Requires physical assistance to complete ADL,, Assist with adl's as needed. Safety: Call light in reach, Remind to call for assist with transfers. Transfer assist of 1, every 15 minute checks." Nursing Progress Notes included: 1/30/20 at 3:11 P.M.: "...order [sic] were received from [name] hospice for Ativan [an anti-anxiety medication with side effects of unsteadiness] and Morphine concentrate [a pain medication with side effects of unsteadiness] prn [as needed]...."			F 0689	F689: It is the policy of this facility to ensure that each resident has a safe environment that is as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. F689: What Corrective Action will be completed by the facility for identified residents? Resident D: Resident D was admitted to the building on 1/28/2020 for end of life care and hospice services. A baseline plan of care was developed with hospice input. Resident was alert and oriented to person, place and time with a BIMS score of 15 on admission to facility. Resident was placed on routine 15 minute safety checks x72 hours per facility admission protocol with no incidents. Resident had a fall risk assessment completed on 1/28/20 that indicated a fall risk of 7, indicating a low risk for falls. IDT team updated POC with subsequent events with new		03/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	2/1/20 at 9:25 P.M.: "I was alerted by [name], [Resident D's] roommate at 2105 [9:05 P.M.] that [Resident D] had fallen and needed help...found [Resident D] sitting on her bottom in front of her recliner with her arms in the recliner. She was alert and oriented asking to get up and go to the bathroom...She had small 2 inch by 0.5 inch pink spot on left frontal lobe where her head hit the ground...I had 2nd RN help me lift patient up from the floor with the help of the patient...Discussed safety and use of call light for help...." 2/3/20 at 12:54 P.M.: "IDT [interdisciplinary team] Meeting Note...Resident on 15 min [minute] and neuro checks...It is noted that resident is newly admitted to facility and it is recommended that resident be encouraged by staff to use call lt [light] for assistance to BR [bathroom], CNA sheet updated to ask resident to toilet often. She is alert and oriented and able to voice wants and needs...." 2/7/20 at 10:10 P.M.: "This nurse called to Resident's room by CNA. When this nurse entered room, 2 Staff members were assisting Resident to bed. Resident had been noted to be on knees facing the bed when CNA answered call light. No injuries noted. Resident did not have shoes or socks on @ that time...Resident stated, 'I had been to the bathroom, and had just gotten back. i [sic] was sitting on the side of the bed, and I slid off.' When asked if she had used walker, Resident stated, 'No.'...Non-skid mat placed in front of bed as preventative. Resident educated to call staff for assist et [and] wear shoes when walking. 15 minute checks initiated." 2/10/20 at 7:48 A.M.: "...stated she did not feel very well...Ibuprofen, Ativan, and Morphine wre		interventions including education, fall mat at bedside, "call don't fall" signs, non-skid footwear when out of bed. Resident was placed on 15 minute monitoring post fall event on 2/12/20 and IDT team determined that the resident was beginning to exhibit signs of confusion/terminal restless. Resident remained on 15 minute safety monitoring until expected death event on 2/17/20. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken. The facility has determined that residents with frequent medication changes (hospice patients) and residents with high fall risks have the potential to be affected. All active facility hospice patients or other patients identified by the IDT team as having frequent medication adjustments have received new Fall Risk Assessments. Care plans and interventions have been updated by the IDT to reflect person centered interventions for updated fall risk scores for these residents. Care plans and fall interventions have been reviewed and updated with person centered interventions for all residents determined by facility Fall Risk Assessment to be at high risk of falls				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	[sic] given. It took assist of 2 plus rolling walker to get to and from the bathroom...Will continue to monitor." 2/11/20 at 2:17 P.M.: "...Is somewhat confused...." 2/12/20 at 3:00 A.M.: "Resident gets up without assistance to BR. Reminded several times to ring call light, CNA watching closely." 2/12/20 at 1:30 P.M.: "Was called to resident room that resident was on floor...asked resident what she was doing she stated I went to bathroom, but it was locked...she turned around and went back to lounge chair and feet were still up a little bit and when she went to sit down she slide [sic] out of the chair and went down on buttock, call light was in reach but was not used...resident was incontinent of urine...fall mat in place in front of bed...reforced [sic] resident to use call light and ask for help, before getting up...." 2/12/20 at 4:21 P.M.: "IDT Meeting Note...It is further recommended per IDT to place call don't fall signs in resident room...." 2/14/20 at 2:58 A.M.: "At 7:15 pm; CNA, [name] came to nurses station...to tell me [Resident D] was in the floor...Upon entering the room, [Resident D] was lying on her left side in front of the BR door, her RW [rolling walker] was near her as if she had been using it. Call light was used, resident was barefoot. She stated that she was in fact going to the BR, but could not explain how she ended up on the floor...Resident c/o [complained of] pain to back and left hip...Room rearranged per sons [sic] request. Resident reminded to please use call light...."		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff will receive education on facility fall policy, fall interventions and identification of root cause of falls. All Licensed nursing staff will be educated on common medications contributing to increased fall risk. Nursing will be educated on completion of new fall risk assessment with change in condition and upon new fall events. Licensed nursing staff will also receive education on increased nursing supervision with increased fall risks. Facility fall investigation packets will be updated to include a ready list of immediate intervention suggestions to implement post fall events including option for pharmacy review of medications that contribute to increased fall risk. Monitoring: Director of nursing or designee will audit a minimum of 10% of fall risk assessments 3x weekly x 4 weeks then weekly thereafter to ensure appropriate person centered interventions for those with high fall risks. Audits will be reviewed through QAPI monthly x6 months or until 100% compliance has been achieved for 3 months. Identified deficiencies will be immediately corrected at				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0744 SS=D Bldg. 00	2/14/20 at 1:29 P.M.: "IDT Meeting Note...Resident is noted to have increase in confusion and becoming weaker r/t [related to] declining condition. It is recommended that resident be toileted every 2 hours and staff to anticipate wants and needs prior...Resident appears to be having increased restlessness..." On 2/27/20 at 8:15 A.M., during an interview with the Director of Nursing (DON), she indicated Resident D received hospice services, and had "terminal restlessness" during her last fall. She indicated she was trying to implement new fall prevention strategies in the facility. On 2/27/20 at 10:20 A.M., the Director of Nursing provided the current facility policy, "Fall Prevention Program," dated May 2015. The policy included: "The fall prevention program emphasizes assessment, identification, and intervention of resident falls...The program identifies the factors that place residents at risk for falls, promotes proactive healthcare practices for resident care planning and identifies the main components of an effective fall prevention program...." This Federal tag relates to Complaint IN00319979. 3.1-45(a)(2) 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial				audit findings then reviewed through monthly QAPI process. QAPI will update plan of correction as appropriate based on audit findings. Date of alleged compliance: March 26, 2020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	well-being. Based on observation, record review, and interview the facility failed to provide an environment that enhanced the quality of life for residents with dementia. The facility failed to add, revise, or implement interventions to reduce the decline of a resident's cognitive status and prevent increased behaviors, such as wandering into other resident rooms, resisting care, or exit seeking behaviors for 3 of 5 residents reviewed for dementia care (Resident F, Resident M, Resident B). Findings include: 1. During the initial tour on 2/25/20 from 9:00 a.m. through 9:45 a.m., it was noted Resident F had been recently hospitalized in an acute psychiatric hospital due to increased behaviors. During an observation on 2/25/20 at 9:30 a.m., during the initial tour, a sign reminding staff and visitors to please wait for the automatic doors to close completely before leaving the area was noted at the entry of the Pavilion Unit. During an observation on 2/25/20 at 2:15 p.m., Resident F was observed on the dementia unit. Resident F had a wanderguard. During an observation on 2/25/20 at 2:17 p.m., a stop sign was noted on the outside of another resident's room. During an observation on 2/27/20 at 7:30 a.m., Resident F was observed on the dementia unit. Resident F had a wanderguard. During a review of Resident F's clinical record on 2/26/20 at 8:52 a.m., the Annual MDS (		F 0744	F 744 Treatment/Services for Dementia. It is the practice of this facility to provide appropriate treatment and services for residents diagnosed with Dementia to attain or maintain his or her highest practical physical, mental and psychosocial well-being. What corrective action will be done by the facility for identified residents: Resident "F" had care plans reviewed and updated by the IDT Team to include non-pharmacological interventions for wandering behaviors. Upon return from acute outpatient stay, this resident was transferred to a smaller unit which has vastly improved his pacing and wandering behaviors. Care plans have been updated to reflect this change of unit and daily routine. Resident "M" has had care plans updated to reflect non-pharmacological behavioral interventions. Resident B is no longer a resident of the facility. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All Dementia resident with a diagnosis of behavioral disturbances have the potential to		03/26/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	Minimum Data Set), dated 1/1/20, indicated Resident F was severely cognitively impaired and had exhibited wandering daily, " intrudes on privacy of others, activities, places resident at significant risk of getting to a potentially dangerous place. Worse since last assessment." Resident F's diagnoses included, but were not limited to, Alzheimer's disease, non-Alzheimer's dementia, unspecified dementia with behavioral disturbance, anxiety disorder, depression, and psychotic disorder. The care plans included, but were not limited to, Resident has a diagnosis of Alzheimer's disease. Utilizes an antipsychotic medication for behaviors related to dementia. Interventions included, but were not limited to, need staff to show me to my room and help to reorient me as needed. Created on 3/5/19, revised 1/15/20. Communication deficit. I need a lot of encouragement and cues from staff to communicate. I will just look at staff and not respond. I can sometimes understand what is being said, respond better to yes or no questions. Interventions included, but were not limited to, I enjoy sitting out in the dining room, involve my family in my care. Created on 3/5/19, revised 12/30/19. I sometimes wander into other resident's rooms due to being unaware of whereabouts. Interventions included, but were not limited to, attempt to redirect me to an activity, ensure that I wear well fitting, non-skid footwear, offer me a snack to divert attention from continuous wandering. Created on 8/15/19, revised 12/30/19.		be affected. Care plans have been reviewed and updated through IDT with patient centered interventions for all residents with identified behaviors. Behavior monitoring has been initiated for any dementia residents with behaviors as identified through the IDT Team. Direct unit care staff have been interviewed to identify any new behaviors that may need to be care planned and monitored. What measures will be put into place to ensure this practice does not recur. Direct care staff have received education regarding new non-pharmacological behavior interventions for residents "F" and resident "M". 1.All nursing staff (to include RN, LPN, QMA, CNA and NA's) and Social Services staff will receive education regarding current Behavior Management Policy including identification, reporting, behavior monitoring and follow-up on documented behaviors. 2.Nursing and social services will also receive education on how to respond when dementia causes unpredictable behaviors. 3. Nursing and social services will receive directed education from Director of Nursing on Person Centered Care Planning of Behaviors until current CoVID19 restrictions allow for a more in-depth in-service protocol from				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	The care plan lacked an intervention related to the wanderguard. I will need invite, encouragement to attend activities. I tend to be more of a passive participant. I do enjoy music, physical games. Interventions included, but were not limited to, I will need for activity staff to encourage me to attend activity, escort to/from. I will need cueing during activity as to what I need to do, music is very important to me so I would like to be included in activities targeting towards music I like all types of music, physical games. The Admission Baseline Care Plan, dated 2/18/20, goals included, but were not limited to, monitor behaviors. Safety interventions included, but were not limited to, wanderguard as needed to prevent elopement, observe for wandering/exit seeking and redirect as needed. An intervention regarding the wanderguard was not documented prior to his return from the hospital on 2/18/20. The care plans lacked new interventions since 12/30/19. The orders included, but were not limited to, Wanderguard, check for placement and function each night shift- initial start date, 8/20/19, restarted upon readmission on 2/18/20. Progress notes indicated, 1/6/20 at 6:20 p.m.- Resident continues to wander around the halls. When resident sees himself in mirror he carries on a conversation. At times resident has gone into other res rooms.			an outside source. 4. New resident behaviors identified through the clinical IDT team will be tracked on a behavior tracking tool for appropriate behavior monitoring and care planning and follow-up by the IDT team. How will the corrective action plan be monitored to ensure the deficient practice does not recur? Director of Nursing or Designee with audit a minimum of 5 care plans 3x weekly of Dementia Residents with behaviors to ensure appropriate care planning and patient centered interventions are in place. At the monthly QAPI meetings the results of the audit tool of care plans and the Behavior Tracking Tool by the DON/Designee will be reviewed. Any concerns will have been addressed as found. Any patterns identified will be reviewed through the QAPI committee.. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution. Date of Expected Compliance: March 26, 2020			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	1/7/20 at 8:57 a.m.- Resident seen on 1/15/20 by [psychiatric services] nurse practitioner for psychotropic medication review. 1/18/20 at 7:07 p.m.- Resident up ambulating in hall attempting to go in other resident rooms. Resident requires frequent redirection. Assisted to nurses station and given a snack of juice and cookies. Medication administration and resident assisted to bed. 1/19/20 at 7:49 p.m.- Resident up ambulating in halls, making repeated attempts to enter other resident rooms. Redirected to nurses' station where he was given snacks and was observed by nurse. 1/20/20 at 3:11 p.m.- Resident continued to wander up and down the hallway. Wandering behaviors , resident followed staff out of 1st door going to the outside, unable to get thru the 2nd door, alarms sounding and staff responded and resident easily redirected back through the door. Resident continues to follow staff and try to get thru doors when they open. 1/21/20 at 1:38 p.m.- Staff reports resident walked about unit most of the day. 1/21/20 at 8:06 p.m.-Resident up ambulating in hall. No attempts to exit unit. Frequently attempts to enter other resident rooms, redirected. Resident currently sitting at desk with nurse having juice and crackers. 1/23/20 at 3:23 p.m.- Resident continues to wander around the unit and go into other rooms that are not his room.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	1/24/20 at 9:20 a.m.- Resident was seen on 1/23/20 by [psychiatric services] for psychotropic med review. 1/27/20 at 6:28 p.m.-Resident wanders in the department and tries to go into other rooms and has to be directed back to main area. Did take pudding cup off of med cart and ate it. 1/28/20 at 2:15 p.m.- Resident up wandering in hall on evening shift. Redirected frequently to prevent resident from entering other resident rooms. Assisted to bed at approximately 9 p.m. and has rested quietly since that time. 1/30/20 at 2:32 p.m.- Resident wandering throughout hallway and went into res room. Resident redirected by staff and assisted to shower and bed. Resident resting in bed at this time. 1/31/20 at 1:22 a.m.- Resident up out of bed and wandering in hall attempting to go in to other resident rooms. When staff attempted to redirect resident became physically aggressive and shoved staff in to door facing. A second staff member then attempted redirection and was successful in taking resident to his room, providing incontinence care and assisting him into bed. Resident currently resting quietly in bed. 2/1/20 at 1:15 a.m.- Resident up wandering halls. Resident was redirected safely back to bed and is resting peacefully. 2/1/20 at 7:37 p.m.- Wanders unit all shift. Going in and out of resident rooms all shift. Tries to get out doors when visitors or employees go through them.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	2/3/20 at 8:41 p.m.- Monitor for sexually aggressive behaviors every shift related to diagnosis of dementia. Resident wanders in and out of rooms and has history of inappropriate behaviors towards female residents and staff. Resident can be easily redirected. Resident likes to sit with staff at nurses station. 2/4/20 at 2:07 p.m.- Resident was up ambulating about unit on evening shift attempting to enter other resident rooms, staff frequently redirecting resident and assisted to nurses' station and given food and drink. This distracts resident for a short period of time before he is up ambulating up and down the halls. Assisted to bed at approximately 9:15 p.m. Resident is currently resting quietly. 2/4/20 at 3:27 p.m.- Resident wandering down the hall and trying to pull off wanderguard on the wall and exit east hall. Resident ignores staff when they tell him to stop and come back down the hall. Resident observed by this nurse pushing key pad buttons to try and get out. 2/4/20 at 3:47 p.m.- Resident quiet this am, has been up pacing through hallways on unit, has set off door alarms several times this shift. Wife here visiting. 2/4/20 at 6:01 p.m.- Resident has paced up and down hallways on the unit, has set alarms off and ton off cover to the wanderguard system. Resident has wandering in and out of other res rooms. Easily redirected. 2/4/20 at 8:43 p.m.- Resident has continued to ambulate up and down halls and in to other resident room and attempting to exit the unit. Almost constant redirection required. Resident						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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		
	has been toileted, given food and drink, and monitored closely by nursing staff. Easily redirected for short periods of time. 2/5/20 at 11:40 a.m.- Resident has been wandering up and down halls of unit all shift. Resident trying to grab anything he can get his hands on, off of the med cart while QMA (Qualified Medication Aide) standing at med cart. Resident given snacks, drinks and redirected many times this shift without much success. Nurse Practitioner from [psychiatric services] here, Depakote (mood stabilizer) increased and Buspar (antidepressant) discontinued. Update on recent behaviors to nurse practitioner. Wife and UM notified of new orders. 2/6/20 at 5:22 p.m.- Increased medications due to increased behavior. No adverse reaction to increase in medications. 2/7/20 at 7:11 a.m.- CNA reported resident squeezing his hands during a.m. care and refusing to let go of CNA. Resident did let go with much encouragement from CNA. 2/7/20 at 6:19 a.m.- Called and notified resident POA regarding resident aggressiveness. POA thanked this nurse for the call. 2/7/20 at 8:17 p.m.- Resident up ambulating about unit. Frequently approaching exits and trying to exit unit. Resident needs almost constant redirection from staff. Frequent offers of food and drink. Toileted every 2 hours. Currently at nurses' station with staff. 2/8/20 at 1:30 p.m.- Activity staff reported that she heard a female resident saying, " get out of here." When she stepped into the hallway she saw						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	this resident coming out of room 703. The resident that occupies 703 was on the floor with her legs in front of her and reported that resident came into her room and hit her causing her to fall down. Unit Director was notified and called DON (Director of Nursing) and Nurse Practitioner for orders. Order for STAT UA C&S, CBC and BMP was received and lab was notified. Resident placed on 1:1 staff monitoring. 2/8/20 at 3:23 p.m.- It was reported this afternoon by nurse manager of the Pavilion unit that resident entered another resident's room, when other resident saw him she yelled " get out," and at that time he approached her and shoved her causing her to fall to the floor. 2/8/20 at 3:55 p.m.- Activity Director heard someone saying " get out of here" as she out of the office to see who it was she saw resident coming out of another resident's room. She looked in her room and resident was on the floor on her butt with legs in front her. When asked what happened she said, "that man was in here and hit me on the arm and I fell. " Activity Director asked resident to stay there while she got the nurse. 2/8/20 at 4:48 p.m.- Nurse Practitioner informed of aggression event towards another resident and lab orders received and order to sent out to ER for evaluation and treatment for acute psychiatric stay and medication evaluation and treatment. The Nurse Practitioner has adjusted resident's medications over the last few weeks and no improvement in wandering. Resident continues to try to exit the unit via multiple doors and enter other resident's rooms. Resident ignores verbal cues and staff have to go get resident and take his						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	hand and lead him back to his room and common area. 2/8/20 at 5:30 p.m.- Resident left building with ambulance service via stretcher for transport to [local emergency room] for evaluation and treatment. Wife aware and will meet resident there. 2/9/20 at 12:52 a.m.- Received call from ER informing facility that resident will be going to [acute psychiatric hospital] for further evaluation and treatment. Spouse in agreement with this. DON and Unit Manager aware. 2/10/20 at 6:06 p.m.- IDT team met for clinical review of resident to resident event. Resident and second resident reside on same hall and their rooms are across from each other. Activity Director for the unit was in her office, which is located across hall and about 3 doors down from these rooms. She reported hearing, " get out" from the hall and immediately exited her office to search for source of voice. Observed female resident on floor in her room sitting on her buttocks. She reported resident had entered her room and she had yelled at him to get out. Female reported he pushed me on my arm and I fell. Nursing called to room for immediate assessment of both residents. Physician notified for residents. Parties for both residents notified of event. DON and Administrator notified. Decision made by Nurse Practitioner to send resident to ER for psychiatric evaluation and potential acute psychiatric stay for medication management. Resident placed 1:1 until transfer out of facility at approximately at 6:00 p.m. Resident was assisted with evening meal prior to transfer. Report called to [local emergency room]. Resident will be evaluated and care plan						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	updated on return to facility. 2/12/20 at 10:09 a.m.- Social worker spoke with resident's wife. She was fine with resident moving to Pathways II when he returned from [acute psychiatric hospital]. Wife will be in today to look at room on Pathways II. 2/12/20 at 6:30 p.m.- IDT team met and reviewed physical aggression entered 2/7/20. Resident was squeezing CNA hand and took much encouragement to let go. This incident was unwitnessed and CNA reported to staff nurse. Nurse notified physician and nurse manager notified via office phone voicemail. Voicemail was reviewed 2/8/20 and spouse notified. Upon follow up with CNA, no injuries from event, but was concerned that resident had this unexpected behavior. IDT team recommended staff education about reporting of behavior and or abuse events of whether direct or indirect housewide and proper notification to family, physician, and management. Resident was sent out on 2/8/20 for psychiatric evaluation and medication review and treatment to [acute psychiatric hospital]. CNA sheets and care plan reviewed. 2/18/20 at 12:41 a.m.- Resident has returned to facility and has been moved to Pathways II unit with all appropriate parties in agreement. Resident oriented to unit, room and staff. Resident initiated on 15 minute checks for new admission to unit and safety checks. Care plan reviewed. 2/19/20 at 12:24 a.m.- Resident returned to facility today at 11:00 p.m. Has remained pleasant this evening with no behaviors. Took medications without difficulty and went to be at 8:30 p.m.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	2/19/20 at 10:53 a.m.- Orders and information obtained from [acute psychiatric hospital] faxed to physician with orders received of CBC, BMP, in morning and okay for therapies to assess and treat. Family aware. 2/19/20 at 3:14 p.m.- Resident seen this day by [psychiatric services] for psychotropic medication review. 2/19/20 at 6:08 p.m.- Has not had any behaviors today. 2/20/20 at 1:24 a.m.- Resident resting in bed, no behaviors noted this shift. 2/20/20 at 3:37 a.m.- Resident rested well tonight. No wandering behaviors noted after placed in bed. A State Reportable, dated 2/8/20 at 3:01 p.m., indicated an incident between Resident F and Resident M. Resident F entered Resident M's room. The other resident told the resident to, "get out." At that time Resident F shoved Resident M, causing her to fall to the floor. The Activity Director was sitting in her office, approximately 3 (three) rooms down the hall from the residents and overheard Resident M yell, "get out." The Activity Director left her office and witnessed Resident F leaving Resident M's room. Resident M was observed sitting on her floor on her buttocks with her legs outstretched. She indicated Resident F shoved her when she told him to leave, causing her to fall. Type of injury: Resident M had a skin tear to						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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		
	posterior left arm in elbow measured 2.5 x 0.5 cm (centimeters). Bruise noted on skin assessment to upper left arm measuring 1.5 x 1.5 cm. Resident M reporting not a new bruise but is blue in color and not previously noted by staff. No injury noted on assessment to Resident F. Action taken: 2/9/20 Staff ensured safety of both residents. Resident M was assessed with injury noted and first aid to area. Weekend Manager notified immediately and participated in investigation. Unit Director, DON, Administrator, and DON notified. Physician for both parties notified and family for both notified. Type of preventative measures added: 2/9/20 Resident F was immediately monitored through 1:1 supervision. Resident M initiated on neuro checks and psychosocial monitoring. Nurse Practitioner for resident ordering UA for Resident F, which was collected. Orders received to transfer Resident F to emergency room for further psychiatric evaluation. Resident M resumed normal activities on the unit. Resident F was transferred to acute facility for further inpatient evaluation. Follow up added on 2/12/20 Nurse Practitioner had been following Resident F extensively for recent medication adjustments as well as the Psychiatric Nurse Practitioner for increased anxiety and inattention on unit. Both nurse practitioners have been in collaboration for Resident F and evaluation and treatment. Orders given for Resident F to be transferred to ER for more extensive evaluation for an acute psychiatric stay. Resident F transferred to ER at approximately 6:00 p.m. and was later transferred to [acute psychiatric hospital] where he remains for inpatient evaluation and treatment.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	Last report on 2/11/20 reporting resident was doing well and responding well with medication adjustments. No definite anticipated return date at this time. Resident M has been monitored and observed daily laughing and interacting with peers and staff and denies fear or discomfort. Continued to be monitored through nursing assessment and will continue to be assessed through social services. IDT team has met in anticipation of return of Resident F to facility from psychiatric inpatient. IDT team in agreement that Resident F, given same cognition on return would fare better on more advanced Pathways dementia unit. Wife contacted and was in full agreement with this tentative plan. IDT to reevaluate cognition on return for further decision on placement in facility. During an interview on 2/26/20 at 1:25 p.m., the DON denied that Resident F had previous behaviors of exit seeking or wandering, and had only tried to remove the wanderguard cover from the wall because he had a previous history of being a mechanic. The incident with CNA 1 and Resident F occurred on 2/7/20 and it was due to Resident F "taking a liking" to CNA 1 and not wanting him to leave the room. The resident grabbed his hands and would not allow him to leave the room. CNA 1 was able to encourage him to let him go. CNA 1 did not have any injuries due to the incident. This was a new behavior, as this had not occurred previously. Resident F had increased with wandering the hall and a "tilted walk." The psychiatric nurse practitioner and the medical nurse practitioner had been working on changing his medications related to the increased behaviors. The incident on 2/8/20 was a surprise because he was having a good day and staff reported he was in the hall talking to himself in the mirror prior to this						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	incident. Felt the other resident may have antagonized him. He was placed on 1:1 immediately and the nurse practitioner was called, labs were ordered, and he was sent out to the ER for a psychiatric evaluation and acute hospital stay. The DON educated the staff on the unit because he had increased behaviors and that was not normal for him. The DON told staff that since the nurse practitioners were working on his medications, all behaviors or changes were to be reported to the nurses to pass along, " every behavior was a behavior." During an interview with Social Worker 1 on 2/26/20 at 1:44 p.m., she indicated she was made aware of Resident F's incidents by reading the progress notes. She checks the progress notes daily on Resident F. Resident F had been having increased behaviors and she did not change or revise his care plan interventions after the 2/7/20 or 2/8/20 incidents. The interventions should have been updated and should have included his wanderguard and the sign posted on the Pavilion doors alerting staff and visitors to ensure the door closed before leaving the area to keep Resident F from following them out. She indicated he was placed on 1:1 with staff after the 2/8/20 incident and then immediately sent out to the [acute psychiatric hospital]. Social Worker 1 indicated Resident F returned to the facility on 2/18/20 and was placed on the Alzheimer's unit, Pathways II. He did have a wanderguard prior his discharge, but did not have one currently. The care plans had not been updated since 12/30/19 and should have been revised when he returned from the hospital or any time he had new behaviors or new interventions. During an interview with the DON on 2/27/20 at						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	7:15 a.m., she indicated Resident F does currently have a wanderguard in place. It was put back into place upon his readmission date 2/18/20. He had a wanderguard in place prior to his acute psychiatric inpatient hospital stay. 2. On 2/25/20 at 2:10 P.M., the closed clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. An admission Minimum Data Set (MDS) assessment, dated 11/14/19, indicated Resident B was severely impaired in her cognition, and required extensive assistance with one staff for dressing and personal hygiene. A Care Plan, dated 11/26/19, indicated, "I have an ADL [activities of daily living] self-care performance deficit r/t Dementia that impedes my safety awareness and decision making skills..." The Interventions included: "Staff may need to adjust my care with interaction based on the my [sic] need at the time care is provided. I req [require] ext [extensive] assistance to total assistance of one staff [with] my bathing/showering needs..." An additional Care Plan, dated 1/2/20, indicated, "I will usually refuse getting a shower, or even allow staff to change my depends and clean me up... I can also become combative and try to swing at staff, or even pinch them. I have told staff that I will take a shower, but in the middle of it I can become verbally/physically aggressive and want it to stop..." The 3 interventions documented, all dated 1/2/20, indicated: "1. I get embarrassed taking a bath in front of others, so I do better if somebody covers me up with a towel						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	while I'm bathing. 2. I like it better is staff gives me a wash rag with soap on it, and then I can clean myself. 3. I will do better taking baths; not showers, as this is what I'm use [sic] to." There were no care plan interventions regarding behaviors documented before or after 1/2/20. Care Plan interventions did not document using 2 staff to provide care. Nursing Progress Notes included the following notations: 1/2/20 at 11:26 A.M.: "This nurse advised that resident was being combative towards staff during her shower today. Unit manager and Social services made aware...." 1/2/20 at 4:11 P.M.: "Two CNA's [sic] were attempting to give resident shower when resident became combative while undressing. Resident tried to leave shower room with no clothes on and both CNAs were able to escort resident back to shower room. Resident continued to be combative and hit one of the CNA's. Resident continued to be combative and hit one of the CNA's. CNA had to hold bilateral arms so she would not be able to strike CNA's [sic] while being combative. Resident calmed down for a short period of time and then while CNA was drying resident off after shower resident became upset again and was trying to leave shower room with no clothes on. CNA was able to get resident to put on short and underwear. Resident left shower room and walked to her room and dressed herself." 1/2/20 at 4:13 P.M.: "Resident has bruising to bilateral forearms from a combative incident towards staff on unit. RFA [right forearm]						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	bruises measure 7 cm [centimeters] x 7.5 cm and 4 cm x 5 cm, deep purple in color, no hardness or swelling. No c/o [complaints of] pain. LFA [left forearm] bruises measure 4 cm x 4 cm and 4 cm x 4 cm, deep purple in color, no hardness or swelling. No c/o pain. POA [power of attorney] aware at this time." 1/3/20 at 9:13 A.M.: "IDT [interdisciplinary team]...meet for a clinical review of witnessed skin alteration event in shower room...Resident is currently a two person assist for care r/t [related to] history of combative behaviors towards staff with personal ADL [activities of daily living] care...[Resident B] did well with initial disrobing and draping, pre [sic] witness, but stood and attempted to begin hitting a CNA with fist. Statements reporting second CNA was fearful that resident would both fall and make contact with second CNA and she was able to reach resident's wrists in attempt to bot [sic] keep resident from falling and prevent her from striking second resident [sic]. CNA's [sic] were able to eventually re-direct resident and get her dressed...Resident has bruising to bilateral wrists/forearm area. IDT team in agreement to continue to monitor skin integrity...IDT team in agreement to attempt to offer alternate bathing times and options...." 1/6/20 at 1:18 P.M.: "Resident refusing care this AM shift. After several attempts this nurse and unit manager were able to give peri care and change residents [sic] brief and pants." 1/7/20 at 11:12 A.M.: "...This nurse and CNA attempted to provide care to resident by getting her dressed, changing her brief and complete peri care. Resident refused...Resident extremely rude to staff...Resident upset and continued to refuse						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	several times...Staff are unable to provide care due to refusal. Social worker and unit manager advised. Staff will attempted [sic] again after lunch." 1/7/20 at 4:32 P.M.: "Resident continues to have bruising to bilateral forearms at this time. No c/o pain or discomfort. Bruises appear red and purple in color...." 1/8/20 at 1:30 P.M.: "Resident resistive to care this AM shift. 2 CNAs were able to get resident cleaned up, brief changed and clothes changed this AM shift. Resident attempted to hit staff members and did pinch both of them on the arms during care." 1/9/20 at 5:55 A.M.: "Resident has refused all night to be assisted to the toilet or to allow the aides to check her brief." 1/10/20 at 6:23 P.M.: "Resident has been very uncooperative today. She did take her morning meds with encouragement but refused afternoon medication. Refusing to come out of room to eat. Resident has been calling assistants [sic] and RN names." 1/11/20 at 6:17 P.M.: "Resident has been uncooperative with her meds and care this evening." 1/13/20 at 5:12 P.M.: "Resident has been resistive to care this shift. CNA this AM shift was able to toilet resident and get her cleaned up after breakfast but resident was not cooperative during this time...." 1/21/20 at 1:57 P.M.: "Resident has been refusing care this day shift. The nurse and CNA						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	have attempted to get resident dressed, change brief and provided peri care. Resident continues to refuse x 4 attempts. Resident hateful to staff and states that she wants to wear the clothes that she has on now and there is no need for her to change...." 1/28/20 at 10:01 P.M.: " Resident refused PM meds and care from staff, declined to be turned, changed and stated that she had already been taken care of and to leave her alone. Will continue to monitor." 2/3/20 at 3:55 P.M.: "Social Service Note...Resident refuses care often, and has issues going outside of her room to eat meals in the dinning [sic] area. POC [plan of care] updated this day...." 2/9/20 at 3:46 P.M.: "Resident noted to refuse shower this AM shift with 2 CNA's [sic] and this nurse present...Resident prior had an incontinent episode of urine while she was sitting in her recliner and refused to let CNA provide care. While this nurse and 2 CNA's [sic] were trying to persuade resident to take a shower her son showered up on the unit and was able to talk her into taking a shower...." 2/11/20 at 3:28 P.M.: "This nurse was advised by night shift nurse that resident refused care from CNA on night shift...and tried to smack CNA while trying to provide care. This nurse advised unit manager [RN 2] and this nurse will advise night shift nurse to put in a behavior noted [sic] on incident when she comes in tonight for her shift." On 2/11/20 at 4:42 P.M., documentation indicated Resident B had the following bruises:						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	Right forearm: 3 cm x 3 cm, 6 cm x 5 cm, 12 cm x 8.5 cm. Left forearm: 4 cm x 4 cm, 2 cm x 2 cm, 3.5 cm x 4 cm, 3 cm x 3 cm, 3.5 cm x 2 cm. The following entries were created as late entries: 2/10/20 at 10:00 A.M., created on 2/11/20 at 10:05 A.M.: "...Discussion with [name of son] r/t [related to] staff concerns r/t resistance to care...failure to want to attend meals and care refusals. [Son] reporting that he wants to be called when mom is resistant to care r/t he feels that even a phone call from him may help her be more compliant...." 2/10/20 at 1:15 A.M., created on 2/11/20 at 10:43 P.M. by LPN 1: "(late entry) reported to nurse by [CNA 3] that she had been in to do bed check for patient. CNA reports that when she attempted to help patient change of her street clothes into pajamas (which she had declined earlier in shift) that patient became angry and cursed at CNA...and while attempting to change shirt the patient struck the CNA as she took the shirt off. New shirt was attempted to be placed on when patient again became more combative. 1 arm in the shirt the CNA walked away from the patient as she was putting the shirt on herself. CNA checked on roommate and as she was exiting the room this patient took her shoe off and threw this at the CNA...Patient was left to calm down." On 2/26/20 at 2:55 P.M., the Director of Nursing (DON) provided statements by CNA 1 and CNA 2. She stated CNA 2 no longer worked at the facility. A written statement by CNA 1, dated 1/2/20,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	indicated, "[CNA 1] and [CNA 2] took [Resident B] to get a shower and she became combative while undressing. Tried to leave shower room with no clothes on. [CNA 1] and [CNA 2] escorted her back to the shower. She became combative and threatened to hit both CNA's [sic] and did hit [CNA 2] while getting her shower and [CNA 2] had to hold her hands while I gave shower. She finally calmed down...While drying her off, [Resident B] became upset and was trying to leave shower room naked. I was able to convince her to put shirt on and underwear but refused bra and she got out of shower room and went to her room...." A written statement by CNA 2, dated 1/2/20, indicated, "[CNA 1] and [CNA 2] took [Resident B] to the shower. While she was undressing she started to become cobative [sic]. Tried [sic] to walk out of shower room with no clothes on. We took her back to the shower. While in shower she became cobative [sic] and started hitting me I had to hold onto both arms. Then she finally calmed down. Then I left." On 2/27/20 at 9:05 A.M., the Dementia Unit Coordinator was interviewed. She indicated she was the staff person who would develop and implement the behavior care plans. She indicated she provided dementia training, and also education to staff, to "step back" if a resident was refusing care. She indicated that Resident B was difficult with any care, and so 2 staff were assigned to her. On 2/27/20 at 9:15 A.M., RN 3 was interviewed. Regarding the bruising incident on January 2, 2020, she indicated she had been out of the facility for an appointment, and when she came back it was reported to her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	that resident was combative in the shower. So she reported the bruising to the Unit Manager. Regarding the bruising on the resident on 2/11/20, RN 3 indicated she noticed the bruising that morning during her medication pass. The resident was unable to tell her how she got the bruises. She did not notice any fingernail marks. She indicated the bruises on the left arm appeared older, and the bruises on the right arm appeared more fresh. On 2/27/20 at 9:20 A.M., CNA 1 was interviewed. CNA 1 indicated she was with the resident on 1/2/20, along with CNA 2. CNA 1 indicated the resident had been resistant to her care "for awhile." Resident B was being "difficult," was sitting on the shower chair, and did not want to take her clothes off. She started getting upset, and stood up; her balance was off, so CNA 2 grabbed her hands to prevent her from falling. CNA 1 "wanted to get her rinsed off and dried." She thought the resident had "smacked" CNA 2. On 2/27/20 at 11:25 A.M., RN 2 was interviewed. She indicated she was the Dementia Unit Nurse Manager. She indicated she was informed after Resident B's shower that Resident B was cooperative at first, but then stood up and hit the staff. The staff grabbed the resident's hands to prevent being hit and keep her from falling. She indicated she did provide education to staff to "just stop and back away" if a resident is resistive to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	care. She did educate CNA 1 and CNA 2. RN 2 indicated no staff was terminated, but that CNA 2 no longer worked at the facility. RN 2 indicated she was not sure, but thought 2 staff were utilized to provide care after that incident. RN 2 indicated that following the 2/11/20 incident, "housewide education" was done regarding documentation. Both CNA 3 and LPN 1 should have documented the resident's behavior. On 2/27/20 at 10:20 A.M., the DON provided the current facility policy, "Behavior Management," dated October 2015. The policy included: "Behavior Monitoring will be in place for each resident of the facility that is...care planned for having exhibited behaviors...The following information should be documented if the behavior is observed: Date, Time, Behavior, Precipitating events, Staff intervention, Outcome. Unit Social Worker will review the behavior monitoring and follow up on documented behaviors. Care plans will be updated and revised to reflect behaviors, effective interventions, and documentation is to be made in a social service progress note...." On 2/27/20 at 12:51 P.M., the DON provided the current facility policy, "Dementia - Clinical Protocol," dated March 2015. The policy included: "...1. For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. 2.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/27/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Nursing assistants will receive initial training in the care of residents with dementia and related behaviors...3. The facility will strive to optimize familiarity through consistent staff-resident assignments. 4. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. 5. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. a. Resident needs will be communicated to direct care staff through care plan conferences...and through written documentation...The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions...."This Federal tag relates to Complaint IN00319979.3.1-37(a)						