STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-MISHAWAKA	**811 E 12TH STREET MISHAWAKA, IN 46544**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure physician's orders were followed for notification of low blood oxygen saturation levels for 1 of 3 residents reviewed for respiratory care, failed to apply a urinary drainage leg bag for 1 of 3 residents reviewed for catheters and failed to apply geri sleeves for 1 of 1 residents reviewed for skin conditions. (Resident G, E and C) Findings include: 1. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's [DIAGNOSES REDACTED]. A physician's order, dated 6/22/2020, indicated Resident G was to receive oxygen at 1-2 liters via nasal cannula if oxygen saturation was below 90% and to check the oxygen (BIOX) saturation every shift and to notify the physician if below 90%. An admission MDS (Minimum Data Set) assessment, dated 6/26/2020, indicated Resident G had a BIMS (Brief Interview for Mental Status) score of 12, moderate cognitive impairment. The Medication Administration Record, [REDACTED]. Nurses notes dated July 13, 14 and 15 lacked documentation to indicate the physician was notified of the low oxygen saturation levels. On 7/29/2020 at 2:26 P.M., the Director of Nursing indicated the physician should have been notified of the abnormal levels. 2. On 7/28/2020 at 11:40 A.M., 12:15 P.M., 12:30 P.M. and 12:51 P.M., Resident E's large urinary drainage bag was observed on the floor while the resident was sitting in his wheel chair. A clinical record review was completed on 7/28/2020 at 2:55 P.M., indicating Resident E's current [DIAGNOSES REDACTED]. A physician's order, dated 2/23/2020, indicated: Foley catheter use leg bag during the day and large UD (urinary drainage) bag to bedside drainage at night. A quarterly MDS (Minimum Data Set) assessment, dated 7/11/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. He required extensive assist of 1 staff for bed mobility and toilet use. A current, 7/6/2020, care plan indicated the resident had the potential for urinary tract infections related to indwelling catheter. The resident refuses at times to use the urinary leg bag. Interventions included, but were not limited to: Secure catheter tubing and catheter appropriately and use leg bag during the day and large UD bag to bedside at night. The TAR (Treatment Administration Record), dated July 2020, indicated the leg bag was initialed as being applied on 7/28/2020. During an interview, on 7/29/2020 at 2:26 P.M., the Director of Nursing indicated there was no documentation of why Resident E did not get a leg bag applied on 7/28/2020. 3. On 7/30/2020 at 9:40 A.M., Resident C was observe to have blood on his left forearm and on his right fingers. A physicians' order, dated 2/4/2020, indicated Resident C was to wear geri sleeves on bilateral upper extremities every shift to help prevent bruising. A care plan, dated 6/26/2020, indicated the resident was at risk for altered skin integrity related to senile purpura-scratches at skin often. Interventions included, but were not limited to: Geri sleeves to BUE (both upper extremities) as resident will allow. I will take off my geri sleeves off and not allow staff to put them back on. At 9:43 A.M., RN 5 was observe to take geri sleeves into Resident C's room. During an interview, on 7/30/2020 at 9:44 A.M., RN 5 indicated Resident C should have had the geri sleeves on. On 7/29/2020 at 3:42 P.M., the Corporate Nurse indicated they did not have a policy for following physicians orders. This Federal tag relates to Complaints IN 779 and IN 853. 3.1-37(a)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to assess for incontinence and to prevent a decline in urinary incontinence for 1 of 3 residents reviewed for urinary incontinence. (Resident B) Finding includes: A clinical record review was completed on 7/30/2020 at 10:17 A.M., indicating Resident B had returned from a hospital stay on 6/20/2020. Her current [DIAGNOSES REDACTED]. A Quarterly Interdisciplinary Resident Review, dated 7/7/2020, indicated the resident was incontinent and no assessment should be completed. A Significant Change MDS (Minimum Data Set) assessment, dated 6/24/2020, indicated Resident B required extensive assist of one staff for toileting, was frequently incontinent of urine and no trial of a toileting program (scheduled toileting, prompted voiding, or bladder training) had been attempted on admission/readmission or reentry or since incontinence was noted in the facility. A Bowel and Bladder evaluation grid, with a completion date 4/3/2018, indicated Resident B was always continent with no leakage/dribbling. The total score was 17. Scores ranging from 16-23 indicated: good candidate for an RNP (Restorative Nurse Program). The form also had the dates of 7/12/2018 no changes, 10/20/2018 no changes and 1/5/2019 no changes. The form lacked any documentation to show the incontinence status had been evaluated since return from the hospital on [DATE]. A care plan, dated 6/18/2020, indicated the resident was at risk for alteration in bladder function related to incontinence, history of urinary tract infections and urine retention. Current interventions included, but were not limited to: check and change before and after meals, upon rising and at hs (hour of sleep) date initiated 6/19/2019, and monitor and report changes in ability to toilet or continence status, date initiated 6/16/2019. Resident B's toileting documentation indicated she had been toileted on: 7/3 at 12:46 PM, 6:00 P.M. 7/4 at 1:48 A.M., 1:57 A.M., and 3:49 P.M. 7/5 at 3:17 A.M., 1:59 P.M. and 4:01 P.M. 7/6 at 3:28 A.M.,12:35 P.M., 9:06 P.M., and 11:42 P.M. 7/7/ at 1:59 A.M., 10:43 A.M., and 11:19 P.M. 7/8 at 9:46 A.M. and 3:53 P.M. 7/9 at 12:34 A.M., 7:25 A.M., and 10:28 P.M. During an interview, on 7/30/2020 at 9:55 A.M., CNA (certified nursing assistant) 12 indicated she toilets Resident B when she gets her up in the morning, and at 10:00 A.M. and after lunch. CNA 12 indicated the resident is usually wet but she will also go on the bed side commode. During an interview, on 7/30/2020 at 11:50 A.M., the Director of Nursing indicated there was no evaluation completed and or a Restorative Nursing Program completed since 1/5/2019. On 7/30/2020 at 11:30 A.M., the Director of Nursing provided the policy titled, Incontinence Management/Bladder Function Guideline, dated 6/8/2015, and indicated the policy was the one currently used by the facility. The policy indicated . Purpose: manage urinary incontinence, restore or maintain as much normal bladder function as possible. Procedure:Evaluation 1. Upon admission (if the resident has a history of incontinence) complete the Bowel and Bladder Tracking Tool. Completed to identify any trends or patterns that the resident may have in relation to incontinence. 2. Complete Bladder Evaluation Form Upon completion of this evaluation as well as the Tracking Tool, the toileting/bladder program can be determined This Federal tag relates to Complaint IN 779. 3.-41(a)(2)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to follow their policy on humidified oxygen therapy and failed to ensure residents requiring the use of oxygen did not have kinked tubing and nasal cannulas in place for 3 of 3 residents reviewed for respiratory care. (Resident F, G and J) Findings include: 1. On 7/28/2020 at 12:42 P.M., Resident J was observed sitting in her room playing with the oxygen tubing which was bunched up in her hand. The nasal cannula was

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

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) not in place and an empty humidifier bottle was attached to the concentrator. On 7/28/2020 at 1:40 P.M., Resident J was observed trying to get up from her wheelchair and indicated, help I need to go to the bathroom. Resident J had her oxygen tubing wound up and was holding it in her left hand. The nasal cannula was not in place and an empty humidifier bottle was attached to the concentrator. On 7/28/2020 at 1:44 P.M., Licensed Practical Nurse (LPN) 4 was summoned to Resident J's room. LPN 4 replaced the nasal cannula in Resident J's nose. During an interview, on 7/28/2020 at 1:45 P.M., LPN 4 indicated Resident J should have had her oxygen on, but she takes it off and the water bottle should have had water in it. On 7/28/2020 at 3:05 P.M., a clinical record review was completed and indicated Resident J was admitted on [DATE]. Her [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 7/26/2020, indicated Resident J had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. Current physician orders [REDACTED]. 2. On 7/28/2020 at 1:03 P.M., Resident F was observe to have an empty humidifier water bottle attached to the concentrator and the nasal cannula prong was only in one nostril. On 7/28/2020 at 1:40 P.M., Resident F's concentrator humidifier water bottle was empty and the nasal cannula was only in one nostril. On 7/28/2020 at 1:51 P.M., LPN 4 was observed to reapply Resident F's cannula correctly. During an interview, on 7/28/2002 at 1:52 P.M., LPN 4 indicated the oxygen should be applied to both nostrils and the humidifier bottle should have had water in it. A clinical record review was completed on 7/28/2020 at 3:30 P.M., and indicated Resident F's [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 5/1/2020, indicated Resident F had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact. A physicians' order, dated 5/11/2020, indicated Resident F was to use 02 continuously via nasal cannula at 4 liters. 3. On 7/28/2020 at 1:03 P.M., Resident G's concentrator was observed to have no humidifier bottle attached to the concentrator. During an interview, on 7/28/2020 at 1:50 P.M., Registered Nurse (RN) 5 indicated she was unsure why there was no water bottle attached to the concentrator, but there should have been one. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 6/26/2020, indicated Resident G had a BIMS (Brief Interview for Mental Status) score of 12, moderate cognitive impairment. On 7/30/2020 at 9:43 A.M., Resident G was in bed with her nasal cannual on top of her head. The oxygen tube connected from the concentrator to the humidifier bottle was kinked and the humidifier bottle was not bubbling (indicating air was not passing into the bottle). On 7/30/2020 at 9:45 A.M., RN 5 was observed to remove the kink from the oxygen tubing for Resident G. On 7/29/2020 at 3:11 P.M., the Director of Nursing provided the policy titled, Oxygen Administration (via nasal Cannula), dated 8/29/2016, and indicated the policy was the one currently used by the facility. The policy indicated .To standardize delivery of low flow concentration of oxygen via nasal cannula to achieve and maintain the desired FiO2 range. Connect the nasal cannula to the oxygen source and turn flow meter to the appropriate flow as ordered by the physician. Ensure good flow through nasal cannula. Ensure tubing is secure to face but not leaving indentations on cheeks or ear areas. Check periodically. Observe for patient sensitivity to oxygen administration, such as nasal dryness, which may indicate the need for humidification. All oxygen administered at 4 liters, or greater will be humidified. Oxygen between 2-4 liters may be humidified according to resident preference/comfort. This Federal tag relates to Complaint IN 853. 3.1-47(a)(6)
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow standards of care of visually observing a resident take their medications for 1 of 1 randomly observed residents. (Resident D) Finding includes: On 7/28/2020 at 11:53 A.M., a plastic medication cup containing 2 white round pills was observed on Resident D's bed side table with the resident sitting in his wheelchair sleeping. During an interview, on 7/28/2020 at 11:58 A.M., Resident D indicated they just brought them in and I take them after my lunch. He indicated his lunch tray would be there in a few minutes. A clinical record review was completed on 7/28/2020 at 2:26 P.M., indicating Resident D's current [DIAGNOSES REDACTED]. A significant change MDS (Minimum Data Set) assessment, dated 5/11/2020, indicated Resident D had a BIMS (Brief Interview for Mental Status) score of 15, cognitively intact. Resident D's current physician orders [REDACTED].M., 2:00 P.M., and 8:00 P.M. On 7/28/2020 at 12:48 P.M., Resident D's lunch tray was delivered. The medication cup with the pills remained on the bed side table. During an interview, on 7/28/2020 at 12:49 P.M., in Resident D's room, QMA (qualified medication aide) 2 indicated the resident takes his medication on his own and she had just brought them in. QMA 2 indicated the medication should not have been left at the bedside and requested Resident D to take the pills then left the room. Resident D took the medication cup and consumed the pills. QMA 2 had already left the room prior to the resident consuming the pills. During an interview, on 7/28/2020 at 12:52 P.M., QMA 2 indicated she should have watched the resident take the pills. On 7/29/2020 at 10:29 A.M., a policy was requested, but one was not provided. 3.1-25(b)(1)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a medication cart was locked when not in view of a licensed staff member for 1 of 1 medication carts randomly observed. (Unit 100) Finding includes: On 7/29/2020 at 9:41 A.M., the medication cart for the 100 hallway was observed to be unlocked with no licensed nursing staff within sight of the medication cart. At 9:42 A.M. RN (Registered Nurse) 10 came out of room [ROOM NUMBER] and walked to the medication cart and locked it. During an interview, on 7/29/2020 at 9:43 A.M., RN 10 indicated the medication cart should have been locked when not in sight. On 7/29/2020 at 3:11 P.M., the Administrator provided the policy titled, Administration Procedures For All Medications, undated, and indicated the policy was the one currently used by the facility. The policy indicated . A. Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide 3.1-25(m)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure urinary catheter tubing and drainage bags were not touching the floor for 4 of 4 residents reviewed for catheters. (Resident E, G, H and K) Findings include: 1. On 7/28/2020 at 11:40 A.M., 12:15 P.M., 12:30 P.M. and 12:51 P.M., Resident E's large urinary drainage bag was observed on the floor while the resident was sitting in his wheel chair. During an interview, on 7/28/2020 at 12:51 P.M., CNA (Certified Nurses Aide) 3 indicated the urinary drainage bag should not be on the floor. A clinical record review was completed on 7/28/2020 at 2:55 P.M., indicating Resident E's current [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/11/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. He required extensive assist of 1 staff for bed mobility and toilet use. A current, 7/6/2020, care plan indicated the resident had the potential for urinary tract infections related to indwelling catheter. The resident refuses at times to use the urinary leg bag. Interventions included, but were not limited to: Secure catheter tubing and catheter appropriately and use leg bag during the day and large UD bag to bedside at night. 2. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's [DIAGNOSES REDACTED]. Current physician's orders [REDACTED]. On 7/29/2020 at 10:50 A.M., Resident G's catheter tubing was observed on the floor under her wheelchair. A care plan, dated 6/22/2020, indicated the resident has an indwelling urinary catheter related to surgical wounds. Interventions included, but were not limited to: keep drainage bag of catheter below the level of the bladder at all times and off the floor. During an interview on 7/3/2020 at 10:51 A.M., CNA 8 indicated the tubing should not be on the floor. 3. On 7/28/2020 at 11:28 A.M., Resident H's urinary drainage bag was observed on the floor. On 7/30/2020 at 9:52 A.M., Resident H's urinary catheter tubing was observed on the floor. A clinical record review was completed on 7/30/2020 at 11:40 A.M., and indicated Resident H's current [DIAGNOSES REDACTED]. A current, 4/9/2020, care plan problem indicated the resident was at risk for urinary tract infections. Interventions included, but were not limited to: secure catheter and tubing appropriately. During an interview, on 7/30/2020 at 9:54 A.M., CNA 3 indicated the tubing should not be on the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) floor. 4. On 7/28/2020 at 11:41A.M., 12:15 P.M., 12:30 P.M., and 12:51 P.M., Resident K's urinary drainage bag was observed on the floor. During an interview, on 7/28/2020 at 12:51 P.M., CNA 3 indicated the drainage bag should not be on the floor. A clinical record review was completed on 7/28/2020 at 2:45 P.M., indicating Resident K's current [DIAGNOSES REDACTED]. On 7/29/2020 at 12:49 P.M., Resident K's catheter tubing and urinary drainage bag was on the floor. During an interview, on 7/29/2020 at 12:50 P.M., CNA 7 indicated the drainage bag and tubing should not be on the floor. On 7/30/2020 at 9:15 A.M., the Administrator provided the policy titled, Preventing Catheter Associated UTI's (CAUTI), dated 8/20/2018, and indicated the policy was the one currently used by the facility. The policy indicated .6. Maintain unobstructed urine flow. a. Keep catheter and tubing free of kinks. b. Secure catheter after insertion to prevent movement. c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor 3.1-18(b)(1)