STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING _____ B. WING _____	03/11/2020

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's representative of a room change for 1 of 1 resident reviewed for notification of change (Resident E). Findings include: Interview, on 3/11/20 at 10:25 a.m., Resident E indicated she was moved to a different room earlier in the month when the facility had to deep clean her room and the exterminator had to treat her room. On 3/11/20 at 10:30 a.m., Resident E's clinical record was reviewed. The [DIAGNOSES REDACTED]. Resident E's Notice of Room or Roommate Change, dated 3/2/20, indicated she was moved from room [ROOM NUMBER] to 306 to allow for treatment to her room. The notice lacked documentation of the resident's representative being notified of Resident E's room change. Resident E's progress notes, dated 3/2/20 through 3/10/20, lacked documentation of resident's representative being notified of her room change. Interview, on 3/11/20 at 2:50 p.m., the Director of Nursing (DON) indicated the clinical record lacked documentation of Resident E's representative being notified of her room change. On 3/11/20 at 2:45 p.m., the Social Service Director (SSD) provided the facility's policy, Resident's Rights for Skilled Nursing Facilities, dated October 2016, and indicated it was the policy currently being used by the facility. A review of the policy indicated, (i) The facility must promptly notify the resident and the resident representative, if any when there is: (A) A change in room . This Federal tag relates to Complaint IN 582. 3.1-5(b)(1)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision to maintain a resident's safety from an agitated resident which resulted in a resident being hit and receiving a fractured nose that required medical intervention for 1 of 1 resident reviewed for accidents (Resident C and D). Findings include: On 3/10/20 at 11:30 a.m., Resident C's clinical record was reviewed. The [DIAGNOSES REDACTED]. Resident C's quarterly Minimum Data Set (MDS) assessment, dated 1/7/20, indicated he had severe cognitive impairment, rejected care 1 to 3 days, and wandered 1 to 3 days. A care plan, initiated on 5/17/19 and current through target date 4/8/20, for Resident C indicated: FOCUS: .The resident has potential for elopement R/T (related to) Dementia .GOAL .Resident will not leave facility unattended .INTERVENTIONS .Offer to take resident for a walk outdoors . A care plan, initiated on 1/7/20 and current through target date 4/8/20, for Resident C indicated: FOCUS: .The resident has a behavior symptom R/T (related to) Dementia E/B (evidence by) wandering, aggression, and inability to anticipate ADL (activities of daily living) need GOAL .Resident will have no evidence of behavior problems entering other res (resident) rooms INTERVENTIONS .entering other res rooms: Attempt non-pharmacological interventions access regularly for toileting needs, redirect with sorting activity, encourage walking throughout the day, encourage 1:1 or group activity/socialization . Resident C's clinical record lacked documentation of monitoring of elopement or physical aggression behaviors. Resident C's progress note, dated 3/8/20 at 3:26 p.m., indicated Resident C was very agitated. He attempted to elope and hit both nurses on duty. He attempted to hit a resident, and he did hit a resident twice. Interview, on 3/10/20 at 1:50 p.m., Certified Nursing Assistant (CNA) 1 indicated she had worked day shift on 3/8/20. Resident C had a history of [REDACTED]. Resident C had not been sleeping well at night and had been agitated with staff. Resident C had tried to leave the facility. Licensed Practical Nurse (LPN) 1 was attempting to redirect Resident C, and he became combative with staff. LPN 1 was going to take Resident C to his room, but Resident C went into the Solarium. LPN 1 had been between Resident C and Resident D. LPN's arm was looped around Resident's C's right arm, and Resident C swung and hit Resident D's nose. Resident D put her hands up to her face to guard her face and Resident C hit her again. Resident C hit Resident D's hands. Resident D received a skin tear to her right hand and her nose was bleeding. CNA 1 did not indicate she offered Resident C a walk outdoors for an intervention for him wanting to leave the facility. Interview, on 3/10/20 at 2:15 p.m., LPN 2 indicated she had worked day shift on 3/8/20, on the west end. She heard a commotion at the front entrance. She observed Resident C trying to attempt to leave the facility, and LPN 1 was trying to redirect him from the front entrance. Resident C was combative with staff. Resident C got more agitated when more staff members tried to redirect him, so LPN 2 went back to the hall she was working. Interview, on 3/10/20 at 3:00 p.m., CNA 2 indicated he had worked on 3/8/20. Resident C had a history of [REDACTED]. Before and after lunch on 3/8/20, Resident C had attempted to leave the facility. CNA 2 did not indicate he offered Resident C a walk outdoors for as intervention for him wanting to leave facility. Interview, on 3/11/20 at 10:15 a.m., the Ombudsman (an advocate for residents in nursing homes) indicated Resident C's wandering and physical aggression towards staff had been going on for 1 year and 3 months. Last summer, Resident C hit his roommate and room change was made with no further known incidents. Interview, on 3/11/20 at 11:30 a.m., LPN 1 indicated she had worked day shift on 3/8/20. She was in the dining room. Resident C was in the dining room and observed a family member leave the front entrance. Resident C went to the front entrance and attempted to leave the facility. When Resident C could not leave, Resident C got agitated. He was slamming doors in the hallway. She tried to redirect Resident C. LPN 2 tried to redirect Resident C. Resident C left the main hallway and headed down the hallway to the 400 hall. On the way down the hallway, Resident C swung at another resident, but did not make contact with her. Resident C headed into the Solarium and LPN 1 was holding onto his right arm, Resident C swung at LPN 1, missed and hit hit Resident D in the nose. Resident C swung again before Resident D could move away. A CNA then moved Resident D away. Resident D had a bloody nose and was sent to the emergency room . Resident D returned from the emergency room with a fracture nose. Resident C had a history of [REDACTED]. LPN 1 did not indicate she offered Resident C a walk outdoors as an intervention for him wanting to leave the facility, nor that other residents were directed away from Resident C while he was agitated. On 3/10/20 at 10:45 a.m., Resident D was observed to be sitting in a recliner in the Solarium on the 400 hall. She was observed to have a green bruise on her nose, 2 dime size purple bruises on her left hand, and 1 dime size bruise with a skin tear (a wound caused shear and/or [MEDICATION NAME] force trauma resulting in separation of skin layers) on her right hand. Resident D's clinical record was reviewed. The [DIAGNOSES REDACTED]. Resident D's progress notes indicated the following: -On 3/8/20 at 1:00 p.m., Resident D was hit by another resident once in the face and once in the facial area with her arms crossed in front of her face. She had bruising to her nose and skin tears to her right arm and hand. Resident D was sent to the emergency room . -On 3/8/20 at 3:46 p.m., Resident D was sent to the emergency room for a possible nasal fracture. -On 3/8/20 at 3:50 p.m., Resident D's husband called. Resident D is being released from the emergency room . She had a nasal fracture. Resident D's emergency room report, dated 3/8/20 at 2:18 p.m., indicated she had a closed nasal fracture. On 3/11/20 at 2:45 p.m., the Social Service Director (SSD) provided the facility's policy,

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Resident's Rights for Skilled Nursing Facilities, dated October 2016, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .(2) The resident has the right to be free from abuse . 3.1-45(a)(2)