STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-ELKHART	**1001 W HIVELY AVE ELKHART, IN 46517**

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 record review and interview, the facility failed to notify resident families of changes in condition, a change in a medication dosage and newly acquired skin conditions for 3 of 3 residents reviewed for family notifications. (Residents B, C, and L). Findings include: 1. A clinical record review was completed on 8/20/2020 at 12:00P.M., and indicated Resident B's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 8/6/2020, indicated Resident B had a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. She required total assist of 1 staff for bathing. A nurses' progress note, dated 2/13/2020, indicated Resident B's [MEDICATION NAME] (antidepressant) medication was changed to 25 mg (milligrams) at bed time. The clinical record lacked the documentation of the family being notified of the medication change. A nurses' progress note, dated 3/3/2020, indicated to monitor bruise to left hand. The clinical record lacked the documentation of the family being notified of the bruise. A nurses' progress note, dated 6/8/2020, indicated Resident B had bruises measuring 12 cm (centimeters) x (by) 5 cm, and one 5 cm x 4 cm due to blood draws. The clinical record lacked the documentation of the family being notified of the skin issues/bruises. A nurses progress note, dated 6/28/2020, indicated the resident had a fall. The clinical record lacked the documentation of the family being notified. 2. A clinical record review was completed on 8/20/2020 at 12:22 P.M., and indicated Resident C's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/22/2020, indicated Resident C had a BIMS (Brief Interview for Mental Status) score of 7, severe cognitive impairment. She required extensive assist of 2 staff for all activities of daily living and was dependant on staff for showering. A nurses' note, dated 6/5/2020 at 12:18 A.M., indicated an aide had notified the nurse of skin areas of concern to the residents lower left and right buttocks. The nurse received a new order for [MEDICATION NAME] three times a day to the area until healed. The clinical record lacked the documentation to show the family was notified of the new skin issue and treatment order. 3. A clinical record review was completed on 8/21/2020 at 12:20 P.M.,and indicated Resident L's [DIAGNOSES REDACTED]. A nurses' progress note, dated 8/6/2020 at 12:54 P.M., indicated Resident L had a coban (adhesive bandage) to her right hand and elbow from earlier blood draws. The nurse removed the bandage and noted a bruise to the right hand measuring 8 cm x 4 cm, 1.5 x 1 to her right elbow and a 3 cm x 2 cm area to her left hand. The clinical record lacked the documentation to show the family was notified of the new skin issues. During an interview, on 8/21/2020 at 10:45 A.M. LPN 4 (Licensed Practical Nurse) indicated they are to notify the families when a resident falls, gets a new order, a change in condition or a new skin issue. During an interview on 8/24/2020 at 12:45 P.M., the Director of Nursing indicated the families should have been notified of the medication changes and the new skin issues and treatments. On 8/21/2020 at 12:48 P.M., the Director of Nursing provided the policy titled, Notification of Change in Resident Health, dated 10/20/2016 and reviewed on 6/24/2018, and indicated the policy was the one currently used by the facility. The policy indicated .To ensure that proper notification are made when a resident has a change in health status. The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: (A) an accident which results in injury and had the potential for requiring physician intervention. (B) Acute illness or a significant change in the resident's physical, mental, or psychosocial status. (C) A need to alter treatment significantly This Federal tag relates to Complaint IN 431. 3.1-5(a)(2) 3.1-5(a)(3)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update care plans for falls for 3 of 5 residents whose care plans were reviewed for falls. (Residents K. N and O) Findings include: 1. A clinical record review was completed on 8/20/2020 at 3:06 P.M., and indicated Resident K's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 6/4/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, intact cognition. She required extensive assist of 1 staff for transfers. A nurses' progress note, dated 8/7/2020 at 4:45 P.M., indicated Resident K was yelling for help. The resident was found sitting on the floor in her room. A care plan, dated 12/24/2018, indicated Resident K was at risk for falls and had not been updated with a new intervention following the fall on 8/7/2020. During an interview, on 8/24/2020 at 1:25 P.M., LPN (Licensed Practical Nurse) 7 indicated the care plan was not updated following the resident fall. 2. A clinical record review was completed on, 8/24/2020 at 1:35 P.M., and indicated Resident N's [DIAGNOSES REDACTED]. A nurses' progress note, dated 8/9/2020 at 6:27 A.M. indicated Resident N returned to the facility from the hospital at 5:00 A.M. A verbal report from the hospital indicated the resident had a scan of the head with no injury noted. A nurses' progress note, dated 8/10/2020 at 4:24 P.M., indicated resident is on post fall observation and neuro assessment. A care plan problem, dated 6/11/2019, indicated Resident N was at risk for falls. The care plan lacked the documentation to show it had been updated. During an interview, on 8/24/2020 at 12:45 P.M., LPN 7 indicated the care plan was not updated following the residents' fall and should have been. 3. A clinical record review was completed on 8/24/2020 at 2:02 P.M., and indicated Resident O's [DIAGNOSES REDACTED]. A nurses' progress note, dated 8/6/2020 at 7:25 P.M., indicated Resident O was found on the floor under the bed side table in her room. A care plan problem, dated 5/18/2020, indicated Resident O was at risk for falls. The care plan lacked the documentation to show it had been updated with new intervention. During an interview, on 8/24/2020 at 12:45 P.M., LPN 7 indicated the care plan was not updated following the resident's fall on 8/6/2020 and should have been. During an interview, on 8/24/2020 at 9:54 A.M., the Director of Nursing indicated the nurse is to assess the resident after a fall. Complete the SBAR form, write a progress note, call the physician, family, Director of Nursing and if receiving hospice call them. We would monitor the resident for 72 hours, complete neurological checks if the fall was unwitnessed and update the care plan with new interventions. On 8/24/2020 at 2:00 P.M., a policy for updating care plans was requested, but one was not provided. 3.1-35(a)(2)(B)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure showers and nail care were provided for 7 of 7 residents reviewed for ADL (Activities of Daily Living) care. (Residents B, C, F, J, K, L, and M) Findings include:

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 1. A clinical record review was completed on 8/20/2020 at 12:00 P.M., and indicated Resident B's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 8/6/2020, indicated Resident B had a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. She required total assist of 1 staff for bathing. On 8/21/2020 at 10:20 A.M., Resident B was observed to have a dark substance under her fingernails with chipped nail polish to 7 nails. A care plan, dated 3/7/2017, indicated Resident B had a physical functioning deficit and was dependent on staff for bathing and was to have nail care weekly and PRN (as needed). A shower schedule for the south hall, indicated the resident was to receive a shower on Mondays and Thursdays on the day shift. Resident B's shower documentation, dated from 7/1/2020 through 8/24/2020, indicated the resident received a shower on 7/6, 7/30, 8/3, 8/13, 8/17, 8/20 and on 8/24/2020. The shower sheet lacked documentation of any shower refusals. Nurses notes, dated 7/1 through 8/24/2020, lacked the documentation to show the resident was refusing showers. No other documentation showing when the resident had received other showers was provided. During an interview, on 8/21/2020 at 10:31 A.M., Unit Manager 2 indicated the nails should not be that way and needed to be cleaned. 2. A clinical record review was completed on 8/20/2020 at 12:22 P.M., and indicated Resident C's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/22/2020, indicated Resident C had a BIMS (Brief Interview for Mental Status) score of 7, severe cognitive impairment. She required extensive assist of 2 staff for all activities of daily living and was dependant on staff for showering. A care plan, dated 2/14/2020, indicated Resident C had a physical functioning deficit and refuses showers and assistance at times. Interventions included, but were not limited to: prefers females for showers as schedule allows. A shower schedule for the 400 hall indicated Resident C was to receive showers on Tuesdays and Fridays on the evening shift. The schedule indicated to complete a shower sheet with all showers/refusals and in Care Tracker and to notify team leader. Resident C's shower documentation lacked the documentation of showers being given from 7/1 to 7/31/2020 and only 2 showers were documented from 8/1/ through 8/24/2020. The nurses notes, dated 7/1/2020 through 8/21/2020 lacked the documentation to show the resident had refused showers. 3. A clinical record review was completed on 8/20/2020 at 3:20 P.M., and indicated Resident F's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 6/29/2020, indicated Resident F had severe cognitive impairment and required total assist for all activities of daily living and was totally dependant for showering. A shower schedule for the 400 hall indicated Resident F was to receive a shower on Wednesdays and Saturdays on the evening shift. The shower documentation from 7/22 through 8/21/2020, indicated the resident only received showers on 7/25 and 8/8/2020. The nurses progress notes, dated 7/22 through 8/21/2020, lacked the documentation to show the resident had refused showers. A care plan, dated 10/12/2018, indicated Resident F had a physical functioning deficit. Interventions included, but were not limited to: bathing- dependent of one staff, clean hands after each meal, clean under fingernails as needed and nail care weekly and PRN (as needed) per licensed nurse. On 8/21/2020 at 11:00 A.M., Resident F was observed to have a dark substance under her fingernails and jagged edges. During an interview, on 8/21/2020 at 11:02 A.M., C.N.A (certified nursing assistant) 5 indicated the residents nails should not be like that and needed to be cleaned. 4. During an interview, on 8/20/2020 at 11:23 A.M., Resident J thought she received her two showers a weekly but wasn't sure. A clinical record review was completed on 8/20/2020 at 12:29 P.M., and indicated Resident J's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 6/10/2020, indicated Resident J had a BIMS (Brief Interview for Mental Status) score of 7, severe cognitive impairment. She required total assist of 1 staff for bathing. A care plan, dated 11/16/2018, indicated Resident J had a physical functioning deficit. Interventions included, but were not limited to: bathing assistance- dependent of one. The shower schedule for the 400 hall indicated Resident J was to receive showers on Mondays and Thursdays on the evening shift. Shower documentation for Resident J, dated 7/1 through 8/24/2020, indicated the resident had received her showers on 7/9, 7/20, and 8/21/2020. On 8/24/2020 at 1:27 P.M., the Director of Nursing provided individual shower sheets for Resident J dated 7/30, 8/10 and 8/21. No other documentation showing when the resident had received a shower was provided. Nurses' progress notes, dated 7/22 through 8/20/2020, lacked the documentation to show the resident had refused showers. 5. During an interview, on 8/20/2020 at 1:25 P.M., Resident K indicated that sometimes she does not get her showers twice a week or nail care. Resident K's fingernails had chipped and missing nail polish and jagged edges. A clinical record review was completed on 8/20/2020 at 3:06 P.M., and indicated Resident K's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 6/4/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, intact cognition. She required total assist of one staff for bathing. A care plan, dated 3/2/2017, indicated Resident K had a physical functioning deficit. Interventions included, but were not limited to: bathing assist-dependent of one staff and nail care weekly and PRN (as needed). The 400 hall shower schedule indicated the resident was to receive showers on Wednesdays and Saturdays on the evening shift. The shower documentation, dated 7/23 through 8/23/2020, indicated Resident K had not received her showers on 7/22 and 8/11/2020. No other shower documentation was provided. 6. On 8/21/2020 at 10:45 A.M., Resident L was observed to have long, dirty and jagged fingernails. A clinical record review was completed on 8/21/2020 at 12:20 P.M., and indicated Resident L's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/13/2020, indicated the resident had severe cognitive impairment. A care plan, dated 3/5/2019, indicated Resident L had a physical functioning deficit. Interventions included, but were not limited to: bathing assistance-staff assist of one, nail care weekly and PRN (as needed). A shower schedule for the south hall indicated Resident L was to receive showers on Tuesdays and Fridays on the evening shift. Resident L's shower documentation, dated 7/1 through 8/24/2020, indicated she had only received showers on 7/7 , 7/21, 7/28, 8/11 and 8/18/2020. Progress notes, dated 7/1 through 8/24/2020, lacked the documentation to show the resident was refusing showers. During an interview, on 8/21/2020 at 10:31 A.M., Unit Manager 2 indicated the nails should not be that way and should have been cleaned. 7. On 8/21/2020 at 10:26 A.M., Resident M was observed to have dirty fingernails with jagged edges. A clinical record review was completed on 8/21/2020 at 1:03 P.M., and indicated Resident M's [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/23/2020, indicated the resident was unable to participate in the mental interview, and had severe cognitive impairment. The resident required total assist for bathing. The shower schedule for the south hall indicated Resident M was to receive showers on Mondays and Thursdays on the evening shift. A care plan problem, dated 4/28/2017, indicated Resident M had a physical functioning deficit. Interventions included, but were not limited to: bathing assistance-dependent of one to two staff and nail care weekly and PRN (as needed). Shower documentation for Resident M, dated 7/1 through 8/24/2020, indicated he had received showers on 7/9, 7/13, 7/23, 7/27, 8/17 and 8/20/2020. Nurses' progress notes, dated 7/23 through 8/21/2020 lacked the documentation to show the resident was refusing showers. During an interview, on 8/21/2020 at 10:31 A.M., Unit Manager 2 indicated the nails should not be that way and should have been cleaned. During an interview, on 8/21/2020 at 10:45 A.M., LPN 4 indicated if a resident refuses to have a shower, they would try another staff member or a different time. They would talk with the resident to verify the refusal and it would be documented on the shower sheets. During an interview, on 8/21/2020 at 10:50 A.M., CNA (certified nursing assistant) 2 indicated the residents are to receive 2 showers per week. CNA 2 indicated if a resident refuses she would document the refusal on the shower sheet and in the computer. During an interview, on 8/21/2020 at 10:55 A.M., CNA 3 indicated she documents the refusals in the computer and fingernails are to be done with showers. During an interview, on 8/21/2020 at 12:29 P.M., the Director of Nursing indicated if a resident refuses a shower, the aide would notify the nurse. The nurse would document the refusal of a shower in the progress notes or on their shower sheet. The Director of Nursing indicated the aide would not document the refusal in the computer. During an interview, on 8/24/2020 at 1:54 P.M., the Director of Nursing indicated they had a problem with shower documentation and could not provide further documentation of residents showers. She indicated they should be receiving showers twice per week. On 8/21/2020 at 1:55 P.M., the Director of Nursing indicated she could not provide policies for bathing, refusal of care and nail care. This Federal tag relates to Complaint IN 720. 3.1-38(a)(3)