STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING _____ B. WING _____	**08/14/2020**

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

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review the facility failed to provide showers for dependent residents for 2 of 3 residents reviewed for Activities Of Daily Living (ADL) (Resident D and G). Findings include: 1. The clinical record for Resident D was reviewed on 8/10/2020 at 2:55 p.m. The resident's [DIAGNOSES REDACTED]. The Quarterly Minimum Data (MDS) assessment , dated 5/5/2020, indicated the resident was cognitively impaired for daily decision making. The resident was totally dependent of two physical staff for bathing needs. The resident's preference sheet, dated 11/19/2019, indicated the resident did not prefer to have more then two showers a week. The resident did not prefer a bed bath over a shower. Review of resident's showers for March, April, May June and July 2020, indicated the resident had not received a shower or a complete bed bath for 5 months and had only received partial baths during this time. During an Confidential interview on 8/13/2020 at 2:40 p.m., the facility had changes in management frequently and this caused lack of guidance and consistency for resident care. Resident D had not been provided a shower for several months. 2. The clinical record for Resident G was reviewed on 8/11/2020 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. The Admission MDS assessment, dated 5/27/2020, indicated the resident was totally dependent of two physical staff for bathing. Review of the resident's shower documentation, dated from 5/20/2020 to 6/2/2020, indicated the resident had not received a shower or full bed bath for the 14 days that he resided at the facility. During an interview with Resident G's family, on 8/13/2020 at 2:45 p.m., they indicated the resident had not had a shower for two weeks while at the facility. When the family picked up the resident from the facility, the resident was unclean and had dirty matted hair. During an interview with the Clinical Education Director on 8/13/2020 at 3:20 p.m., she indicated the floor nurse should have been ensuring residents were receiving showers. The CNA's would be responsible to to check their shower assignments every day to see which residents were scheduled for showers. The facility was now going to have the Assistant Director of Nursing Services (ADNS) ensure showers were being provided for residents. The bathing policy provided by the Executive Director on 8/14/2020 at 1:30 p.m., indicated the purpose of the policy was to cleanse and refresh the resident, observe the skin and provide increased circulation. This Federal tag relates to Complaints IN 441 and IN 039. 3.1-38(a)(3)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an assessment for a deep tissue pressure ulcer and to complete a weekly and accurate skin assessments resulting in the resident acquiring a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident G). Findings include: The clinical record for Resident G was reviewed on 8/11/2020 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 5/27/2020, indicated the resident required extensive assistance of two physical staff for bed mobility, the resident did not ambulate. The resident was totally dependent of two physical staff for bathing. The resident had an unstageable pressure ulcer and was at risk for developing a pressure ulcer. The wound assessment, dated 5/20/2020, indicated the resident had a suspected deep tissue injury on the coccyx measuring 10 centimeters cm by 10 cm. The pressure ulcer was red/purple in color. The wound assessment, dated 5/23/2020, indicated the resident had a suspected deep tissue injury on the coccyx measuring 10 centimeters cm by 10 cm. The pressure ulcer had no change. There were no further assessments for this wound documented. This indicated the resident went 10 days without a wound assessment. The Physical Therapy plan of care, dated 5/20/2020, indicated the resident had a fall at home in February 2020 and sustained a cervical fracture. The resident underwent [REDACTED]. The resident's injury resulted in [MEDICAL CONDITION], and had been using a cervical collar since then. The progress note, dated 6/2/2020 at 10:58 a.m., indicated the resident was being discharged to home with family. The resident's family member removed the resident's cervical collar and his head revealed a stage 2 pressure ulcer on the back of his skull. The pressure ulcer was white and moist. The area measured 2 cm by 2.5 cm. Review of the resident's shower documentation, dated from 5/20/2020 to 6/2/2020, indicated the resident did not receive a shower or full bed bath for the 14 days that he resided at the facility. During an interview, on 8/13/2020 at 12:10 p.m., the Director of Nursing Services (DNS) indicated she was unable to find another wound assessment on the suspected deep tissue injury on the coccyx for Resident G after 5/23/2020. She was unable to find any physician's orders [REDACTED]. The admitting nurse should have called the hospital and received clarification for care of the cervical collar and if could be removed or not. During an interview, on 8/13/2020 at 2:45 p.m., Resident G's family member indicated the resident's normal routine at home was to shower every other day. The family member indicated during showers the cervical collar was taken off to ensure his skin was intact and he was clean. The facility had not provided showers to the resident or remove the cervical collar for 14 days and the resident acquired a pressure ulcer on his head as a result of this. The bathing policy provided by the Executive Director, on 8/14/2020 at 1:30 p.m., indicated the purpose of the policy included, was not limited to, to observe the skin. The skin integrity policy provided by the Executive Director, on 8/14/2020 at 1:30 p.m., indicated the purpose was to provide a comprehensive approach for monitoring skin conditions and promote healing of wounds. The licensed nurse would be responsible for performing a skin evaluation weekly and document on the wound evaluation flow sheet. The facility would develop a routine schedule to review residents with wounds or at risk on a weekly basis and document findings. CNA's would complete a bath/shower worksheet and turn it into the licensed nurse. If any skin alterations were identified, the licensed nurse would follow up re the skin integrity guideline. This Federal tag relates to Complaint IN 309. 3.1-40
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to address and implement interventions for a resident's significant weight loss for 1 of 3 resident's reviewed for nutrition (Resident H). Finding include: The clinical record for Resident H was reviewed on 8/12/2020 at 2:50 p.m. The resident's [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/2020, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of one physical staff member for eating. The resident's weight was 176 and he had a weight loss of more then 5 % (percent). The resident was not prescribed a weight loss regimen. The resident's weights were as follows: - 4/2/2020 the resident weighed 198 pounds - 5/6/2020 the resident weighed 183 pounds The weight loss indicated a 7.58 % weight loss in one month. - 6/3/2020 the resident weighed 175 pounds This indicated a 9.84 % weight loss in one month. - 7/3/2020 the resident weighed 166 pounds This indicated a 5.14% weight loss in one month. - 8/3/2020 the resident weighed 152 pounds This indicated a 8.43 % weight loss in one month. The resident had 16.16 % in three months between 4/2/2020 and 7/3/2020. During an interview, on 8/12/2020 at 2:45 p.m., the Director Of Nursing Services (DNS) indicated she would investigate the residents weight loss since she was unable to find documentation that the facility addressed the

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) weight loss or implemented interventions for the resident's weight loss. During an interview, on 8/13/2020 at 10:40 a.m., the DNS indicated the Interdisplinary Team (IDT) had talked about Resident H's significant weight loss on 8/5/2020, but did not implement any interventions at that time because the resident was on palliative care. The facility had implemented a magic cup for Resident H on 5/20/2020 one time a day and on 8/12/2020 increased it to two times a day. The Registered Dietician (RD) would have been responsible to address the resident's significant weight loss. The facilities RD stopped working at the facility in May 2020. During an interview, on 8/13/2020 at 12:37 p.m., the Dietary Manager indicated the facilities protocol for residents with significant weight loss was the nurse would notify the Dietary Manager of a significant weight loss and the resident would be placed on Patient at Risk (PAR) meeting and supplements and interventions would be implemented. The Dietary Manager indicated she was not notified of Resident H's significant weight loss. During an Confidential interview on 8/13/2020 at 2:40 p.m., the facility staff had not been assisting residents with eating like they needed to be and the facility had not been addressing residents with weight loss. The nutrition policy provided by the Executive Director on 8/14/2020 at 1:30 p.m., indicated All significant changes, losses as well as gains, must be discussed and interventions determined by all members. Persistent losses and gains should not be over looked. Interventions must be implemented to prevent these losses or gains from becoming significant. The responsibility of this committee is to assure the needs of the resident are met to prevent or stop an undesirable significant change. The recommended interventions should be tailored to the resident and not cookie cutter solutions such as automatic orders for supplements. The expertise of each team member should be utilized when developing a plan of care and all are encouraged to find creative interventions. Once implemented, interventions must be monitored for effectiveness and acceptance by the resident. If desired results are not obtained the interventions my be changed. It is recommended that monthly significant weight changes of 5 % in one month, 7.5 % in 3 months and 10% in 6 months be documented in the form of an situation-background-recommendation-assessment tool (SBAR) in point click care by nursing staff. This Federal tag relates to Complaint IN 441. 3.1-46