STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	10/19/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRENTWOOD	**30 E CHANDLER AVE EVANSVILLE, IN 47713**

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 0155 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system in place to determine code status for 2 of 2 residents who were not provided Cardiopulmonary Resuscitation. The facility failed to perform Cardiopulmonary Resuscitation (CPR) on a resident who had requested to be a full code. (Resident #51) The facility failed to obtain a valid code status for Resident #36. (Resident #51, Resident #36) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when the staff failed to provide CPR for a resident without a valid Advanced Directive. The Administrator and DON were notified of the Immediate Jeopardy on [DATE] at 1:40 p.m. The Immediate Jeopardy was removed on [DATE] at 3:01 p.m., but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. On [DATE] at 10:51 a.m., Resident #51's clinical record was reviewed. Resident #51's [DIAGNOSES REDACTED]. The Indiana Physician order [REDACTED].#51, which would have indicated whether Resident #51 wanted life sustaining measures in the event of a [MEDICAL CONDITION], was incomplete and not signed by a physician. The document did not have a date of resident's signature. A recapitulation of Resident #51's most recent hospitalization on [DATE] indicated Resident #51 was a full code in the event of a [MEDICAL CONDITION]. The physician's recapitulation orders, signed [DATE], lacked an identified code status. The Nursing Home/Assisted Living Facility visit, from Resident #51's physician, dated and signed on [DATE], indicated Resident #51 was a full code. The Nursing Progress Notes, entered as a late entry on [DATE] at 3:00 a.m., for [DATE] at 5:00 a.m., included, but was not limited to: Resident is in bed at present time. Respirations and all pulses have ceased. Skin color is ash color, cyanotic fingertips, and skin is cool to touch. Pupils are fixed and dilated. No s/s (signs or symptoms) or evidence of activity from resident. Resident's status confirmed by second nurse on duty. (No CPR was initiated or performed for the resident.) On-call MD (Medical Doctor) and family notified and CPR (Cardiopulmonary Resuscitation) order discontinued per MD .The entry was completed by LPN #5. On [DATE] at 3:30 p.m., LPN #5 was interviewed. LPN #5 indicated she had walked into the resident's room and found him without evidence of vital signs and walked out to the nurses station to check the resident's code status. LPN #5 indicated there was not an Advanced Directive in the resident's chart. At that time, LPN #5 indicated she was unaware of how to proceed and contacted the physician. LPN #5 indicated the physician instructed her to make Resident #51 a DNR (Do Not Resuscitate). LPN #5 indicated she had not performed CPR on Resident #51. LPN #5 was asked to describe what should happen when a resident is found without vital signs. LPN #5 indicated one nurse should contact the physician and another nurse should retrieve the crash cart. When queried regarding who would initiate CPR and who would call for the emergency services, LPN #5 indicated the nurse who contacted the physician would call the emergency services. The nurse who retrieved the crash cart, should initiate CPR. When queried regarding the late entry of charting surrounding Resident #51's death, LPN #5 indicated she had been exhausted and could no longer think. 2. On [DATE] at 12:10 p.m., Resident #36's clinical record was reviewed. Resident #36's [DIAGNOSES REDACTED]. Resident #36's Do Not Resuscitate/Do Not Intubate Request, was signed by the physician on [DATE]. (The resident died on [DATE].) The Electronic Health Record indicated Resident #36 was a full cardiac code, ordered on [DATE]. The Nursing Progress Notes, dated [DATE] at 12:55 a.m., included, but was not limited to: Resident is in bed at present time. Daughter notified and arrived at bedside. Resident is non-responsive. Color ashy and cool to touch on extremities. Cyanosis noted to all four extremities. Bilateral blood pressure absent, pulses absent, and respirations absent. Verified resident's condition by two on staff nurses. MD notified and new orders received. On [DATE] at 3:30 p.m., LPN #5 was interviewed. LPN #5 indicated Resident #36 was a hospice patient. LPN #5 further indicated she figured most hospice patients are not resuscitated. LPN #5 indicated the resident was expected to die because of hospice services. When queried regarding a resuscitation order, LPN #5 indicated she was unsure of Resident #36's code status. On [DATE] at 11:56 a.m., the Administrator provided the Cardiopulmonary Resuscitation (CPR) Guideline, created on [DATE] and reviewed on [DATE]. The policy included, but was not limited to: In the event a resident/patient experiences [MEDICAL CONDITION], cardiopulmonary resuscitation will be provided in the absence of a valid Advanced Directive or a Do Not Resuscitate (DNR) order directing others. If a patient/resident is found unresponsive, begin evaluation to determine presence or absence of pulse and/or respirations. In the absence of pulse and/or respirations do the following: 1. Remain calm. 2. Call out for help. Direct another staff member to announce the emergency per (Name of Facility) protocol and call Emergency Medical Services (EMS). Direct another staff member to bring the emergency supplies and AED (Automated External Defibrillator). 3. A charge nurse will assume command of the scene and will direct other personnel in the effort. CPR certified personnel, when present in facility, shall manage the physical efforts involved in resuscitation. 4. A staff member other than the one who is providing the resuscitative effort must promptly identify/validate current code status. While that step is undertaken, AED should be prepared and [MEDICATION NAME] placed. 5. If DNR status is validated, do not initiate CPR. If CPR/Code Status is undetermined, CPR will be initiated and will continue until the arrival of EMS . 7. Once resuscitative efforts are concluded or resident/patient is transported to emergency center: call attending/covering physician, call resident/patient family, document details of CPR in record On [DATE] at 12:05 p.m., the DON indicated if staff members found a resident unresponsive they were to initiate the CPR policy and procedure. 3XXX,[DATE](f)(5)
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating**

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** Based on interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the state agency for 1 of 3 abuse allegations reviewed. (Resident H) Findings include: On 10/5/15 at 11:24 a.m., Resident H indicated she had been verbally abused and had notified staff of the incident. On 10/13/15 at 11:39 a.m., the Administrator indicated he was unaware of an incident which involved Resident H. On 10/13/15 at 12:06 p.m., the DON was interviewed. The DON indicated she had received a phone call regarding an incident with Resident H. The nurse she spoke with indicated the CNA had showed a low frustration tolerance. The DON indicated she had interviewed Resident H the evening of the alleged incident. The DON indicated Resident H had stated she had asked the CNA how he was doing and stated he had to save his voice for a lot of patients to save his energy. Resident H told the DON the next time she rang her call light and the CNA came to the door and asked what she wanted. The DON indicated Resident H stated the CNA dropped a box trying to move things out of the way. The DON queried Resident H and asked if the CNA had been mean or if he had been unprofessional. At that time, Resident H stated he had been unprofessional. The DON indicated after she had discussed the issue with the resident she had not felt it needed to be reported. On 10/13/15 at 3:38 p.m., the Grievance Form was provided. The Statement of Concern indicated: Resident stated CNA was hateful and mean .CNA kicked box in her room. The Nature of Resolution indicated: No further incidents and resident moved to a different hall, CNA not to provide care for resident. On 10/14/15 at 9:28 a.m., CNA #10 indicated she was the employee who Resident H had reported the alleged abuse to. CNA #10 further indicated she notified the DON. CNA #10 indicated on the evening of the alleged abuse, she had entered Resident H's room. CNA #10 indicated Resident H's eyes were watery, but stated she had not wanted to get anyone in trouble. Resident H further indicated to CNA #10 she had wished CNA #10 was still caring for her. CNA #10 questioned Resident H further and Resident H indicated the following: Upon pressing the call light the CNA who had been caring for Resident H looked in the room and asked Resident H what the resident had wanted. Resident H indicated the CNA had kicked a box of her belongings. Resident H had asked that CNA how the CNA was and the CNA stated he did not have time to speak to her because he had other residents to care for. CNA #10 indicated at that time Resident H felt the CNA that had been caring for her was rude and hateful. CNA #10 indicated she instructed the CNA not to enter the resident's room, informed the nurse of the situation, and contacted the DON. CNA #10 indicated she had written the information on a grievance form. On 10/14/15 at 1:30 p.m., the DON provided the Reporting Alleged Abuse Violation policy, dated 1/15/15. The policy included, but was not limited to: It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violation) are reporting (sic) immediately to the executive director of the center. Such violations are also reported to state agencies in accordance with existing state law. This Federal tag relates to Complaint IN 502. 3.1-28(c)
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** Based on interview and record review, the facility failed to follow their abuse policy. 1 of 3 resident abuse allegations was not immediately reported to the state survey agency. (Resident H) Findings include: On 10/5/15 at 11:24 a.m., Resident H indicated she had been verbally abused and had notified staff of the incident. On 10/13/15 at 11:39 a.m., the Administrator indicated he was unaware of an incident which involved Resident H. On 10/13/15 at 12:06 p.m., the DON was interviewed. The DON indicated she had received a phone call regarding an incident with Resident H. The nurse she spoke with indicated the CNA had showed a low frustration tolerance. The DON indicated she had interviewed Resident H the evening of the alleged incident. The DON indicated Resident H had stated she had asked the CNA how he was doing and stated he had to save his voice for a lot of patients to save his energy. Resident H told the DON the next time she rang her call light and the CNA came to the door and asked what she wanted. The DON indicated Resident H stated the CNA dropped a box trying to move things out of the way. The DON queried Resident H and asked if the CNA had been mean or if he had been unprofessional. At that time, Resident H stated he had been unprofessional. The DON indicated after she had discussed the issue with the resident she had not felt it needed to be reported. On 10/13/15 at 3:38 p.m., the Grievance Form was provided. The Statement of Concern indicated: Resident stated CNA was hateful and mean .CNA kicked box in her room. The Nature of Resolution indicated: No further incidents and resident moved to a different hall, CNA not to provide care for resident. On 10/14/15 at 9:28 a.m., CNA #10 indicated she was the employee who Resident H had reported the alleged abuse to. CNA #10 further indicated she notified the DON. CNA #10 indicated on the evening of the alleged abuse, she had entered Resident H's room. CNA #10 indicated Resident H's eyes were watery, but stated she had not wanted to get anyone in trouble. Resident H further indicated to CNA #10 she had wished CNA #10 was still caring for her. CNA #10 questioned Resident H further and Resident H indicated the following: Upon pressing the call light the CNA who had been caring for Resident H looked in the room and asked Resident H what the resident had wanted. Resident H indicated the CNA had kicked a box of her belongings. Resident H had asked that CNA how the CNA was and the CNA stated he did not have time to speak to her because he had other residents to care for. CNA #10 indicated at that time Resident H felt the CNA that had been caring for her was rude and hateful. CNA #10 indicated she instructed the CNA not to enter the resident's room, informed the nurse of the situation, and contacted the DON. CNA #10 indicated she had written the information on a grievance form. On 10/14/15 at 1:30 p.m., the DON provided the Reporting Alleged Abuse Violation policy, dated 1/15/15. The policy included, but was not limited to: It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violation) are reporting (sic) immediately to the executive director of the center. Such violations are also reported to state agencies in accordance with existing state law. This Federal tag relates to Complain IN 502. 3.1-28(a)
F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** Based on observation, record review, and interview, the facility failed to provide assistive devices to a resident who requested side rails, for 1 of 1 residents who requested side rails. (Resident K) Findings include: On 10/8/15 at 8:40 a.m., during an interview with Resident K, he indicated that he had asked for side rails on his bed to help him turn himself, and was told he could not have them because of some law, he could not remember exactly what they said. He indicated that he could not turn himself in bed, he had to have help. He said he gets out of bed 3-4 hours a day, goes to therapy and gets in his wheelchair. He said he lied mostly on his back, and did not get turned on a schedule. On 10/8/15 at 9:05 a.m., during an interview with the Director of Nursing, she indicated she did not know why Resident K did not have side rails if he requested them.

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) On 10/08/15 at 9:39 a.m., the Director of Nursing indicated that the side rails had been ordered previously, and that maintenance was putting side rails on Resident K's bed that had came from another bed in the facility, until Resident K's side rails come in. On 10/08/15 at 1:25 p.m., the Director of Nursing indicated that the side rails had previously come had been delivered in June or July, but had to be sent back due to damage. She also indicated the reason the resident had not had side rails put on was because he had not signed the initial consent form for side rails. On 10/8/15 at 10:00 a.m., during record review of Nursing notes dated 8/27/15, it was charted that Resident K accepted a.m. meds whole, request side rails to be able to move self about bed . endorsed to on coming nurse. 3.1-3(u)(3)
F 0258 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Maintain comfortable sound levels.** Based on observation and interview, the facility failed to maintain a comfortable noise level. The facility mows the grass in the early morning for 2 of 35 residents interviewed during Stage 1. (Resident P, Resident T) Findings include: On 10/6/15 at 8:39 a.m., Resident P and Resident T were interviewed. They indicated a lawn service cut the grass every Tuesday at approximately 5:00-5:30 a.m., on that day. On 10/13/15 at 8:00 a.m., the lawn service was observed to have completed cutting the grass. On 10/15/15 at 11:10 a.m., the Maintenance Assistant indicated a lawn service cut the grass one time per week during the summer months. The Maintenance Assistant indicated the lawn service was usually finished by the time he arrived or they were finishing blowing the grass off of the walkways. This Federal tag relates to Complaint IN 592. 3.1-19(f)
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to complete a comprehensive accurate assessment for 2 of 39 resident's reviewed during Stage 2 of the survey. (Resident #107, Resident V) Findings include: 1. On 10/13/15 at 3:30 p.m., Residents #107's records were reviewed. The Admission weight on 5/23/15 was 161 pounds. The Minimum Data Set (MDS) 30 day assessment dated [DATE], indicated the resident's weight to be 139 pounds. The MDS was not coded for a significant weight loss for Resident #107. On 10/14/15 at 12:53 p.m., the MDS Coordinator indicated that the Dietary Manager usually did Section K on the MDS, unless there was a feeding tube, and if by chance she was the one who did the assessment, then it was an error on her part. She then acknowledged that she had coded Resident #107 wrong on the MDS for weight loss. 2. On 10/13/15 at 12:23 p.m., during record review of Resident V, the quarterly Minimum Data Set ((MDS) dated [DATE], indicated the resident had no impairments of upper or lower extremities. The quarterly MDS dated [DATE] indicated the same. The 14 day MDS dated [DATE] , also indicated no impairments of the upper or lower extremities. A progress note dated 8/28/15 indicated Resident V was recently on Physical Therapy and Occupational Therapy caseload for wheelchair positioning and contracture management. discharged from services 1 week ago. A nursing note dated 8/26/15 indicated to ask the family to provide some stretchy clothes for the resident, pants, sweatshirts, socks. The ones he currently has are difficult to fit over his increasing contractures. Nursing notes, dated 5/6/15, indicated resident is incontinent of bowel and bladder, contracted, and requires total care with activities of daily living, positioning in bed, fed by staff. Program notes dated 8/31/15 indicated recently received Physical therapy, Occupational therapy ., and no further decline in contractures noted . will discontinue program at the time, will re-evaluate for further programming at later date. On 10/14/15 at 12:51 p.m., during an interview with the MDS Coordinator (Minimum Data Set), she indicated that she had her own worksheet where she kept track of contractures. She indicated that she did not code the MDS for contractures if they do not impede a residents daily living, or put them at risk for injury. She indicated this is her interpretation of the MDS. She indicated Resident V usually does not feed himself, and at times can drink on his own. On 10/15/2015 at 3:39 p.m., Registered Nurse #1 indicated Resident V had a contracture to his right arm, and was no longer receiving therapy. On 10/15/15 at 3:42 p.m., Resident V was observed lying in bed. He was able to move his left arm up in the air upon request, but unable to move his right arm up in the air upon request. 3.1-31(a)
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan based on the comprehensive assessment. The clinical record lacked a care plan for urinary incontinence, contractures, psychoactive medications, and intellectual disabilities for 4 of 39 people reviewed during Stage 2 of the survey. (Resident U, Resident I, Resident D, Resident #117) Findings include: 1. On 10/5/15 at 2:15 p.m., LPN #1 indicated Resident U had a contracted left hand. On 10/13/15 at 8:57 a.m., Resident U was observed in bed. On 10/14/15 at 3:02 p.m., the DON indicated Resident U had been receiving range of motion services from the restorative aid but now received range of motion services from the CNA's during his daily morning care. On 10/14/15 at 3:13 p.m., CNA #1 and CNA #2 indicated Resident U received range of motion services from the restorative aid. On 10/14/15 at 11:05 a.m., Resident U's clinical record was reviewed. Resident U's Quarterly MDS (Minimum Data Set) Assessment, dated 9/17/15, indicated Resident #U had a functional limitation of both upper and lower extremities. The Care Plans included, I have a physical functioning deficit, initiated on 8/19/15. The interventions included, but were not limited to, bilateral hand splints per physician order. On 10/14/15 at 1:08 p.m., the MDS Coordinator indicated range of motion was included on the Activities of Daily Living Care Plan. The MDS Coordinator indicated the bilateral hand splints were the only intervention related to Resident U's contractures in the care plan. On 10/15/15 at 9:09 a.m., CNA #3 indicated yesterday (10/14/15) was the first day she had provided restorative range of motion services for Resident U. 2. On 10/13/15 10:06 a.m., CNA #1 and CNA #2 were observed to provide incontinence care for Resident I. On 10/13/15 at 4:08 p.m., Resident I's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/22/15, indicated Resident I was always incontinent. The Care Plans included, but was not limited to: Pressure ulcer actual or at risk, initiated on 8/15/13. The interventions included, but were not limited to, provide thorough skin care after incontinent episodes and apply barrier cream. On 10/14/15 at 10:51 a.m., CNA #2 indicated Resident I was incontinent and the staff checked the resident for incontinence every two hours. On 10/14/15 at 1:08 p.m., the MDS Coordinator indicated urinary incontinence does not have its own separate care plan. The MDS Coordinator further indicated the interventions for urinary incontinence were included in the pressure ulcer care plan. The MDS Coordinator indicated the only intervention related to urinary incontinence for Resident I was to provide skin care after incontinence episodes. On 10/19/15 at 7:45 a.m., the Administrator provided the Interdisciplinary Care Plan policy, dated 2/26/15. The policy

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) included, but was not limited to: The interdisciplinary care plan is implemented to guide the (Name of Company) in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well being of the resident 3. On 10/7/15 at 9:23 a.m. record review of Resident D was done which indicated the resident had the following diagnoses that included, but were not limited, pneumonia, [MEDICAL CONDITION], dementia, anxiety, major [MEDICAL CONDITION], Parkinson, paralysis agitans, [MEDICAL CONDITION] bladder, [DIAGNOSES REDACTED], generalized anxiety disorder. On 10/07/2015 9:23 a.m. the clinical chart review for Medications included, but not limited to: [MEDICATION NAME] (anti-psychotic) 150 mg by mouth at bedtime- related to [MEDICAL CONDITION] order. On 4/13/15- Changed from [MEDICATION NAME] (anti-psychotic) On 8/7/15 Behavior Health Progress note indicated resident worries, also Resident D had changed [DIAGNOSES REDACTED]. The nursing notes indicated the following behaviors: On 9/6/15 at 5:08 p.m., the notes indicated Resident D was playing cards with other residents. Another resident picked up a card, in which Resident D became agitated and punched the other in the stomach with his hand/fist. Resident D was asked what happened and this resident could not remember or chose not discuss the event, making random statements that were almost nonsensical and denies any happenings Resident's daughter was notified and resident was placed on 15 min checks for 72 hours to assure continued safety and stability An incident report was made out for this incident. On 10/12/15 at 4:01 p.m., the notes indicated the resident had made a derogatory comment to a resident. He told the resident to get the f*** out of here. He also was calling another person a tattletale. The resident was noted to be sitting in his room quietly throughout the day or in activity room playing cards. On 2/26/15 the Annual MDS (Minimum Data Set) Assessment indicated no behaviors. On 10/7/15 at 3:18 p.m. an interview with Social Services (SS) about behaviors of in Resident D. She indicated had dementia secondary to [MEDICAL CONDITION], and was probably a candidate for Alzheimer's unit. She indicated Resident D's behaviors were he gets agitated, abrupt with answers, very nervous and cries about wanting to go home to his wife. SS indicated Resident D was involved in an incident playing cards. Resident D went to stop another resident from taking his card and with open hand fist they each punched each other in the stomach. SS indicated there are no behavior tracking sheets, all behaviors are charted in the nursing notes and then reviewed the next day during daily meetings. SS indicated Resident D has had no behaviors except for one the other day. On 10/15/15 at 12:13 p.m., an interview with DON indicated Resident D needs the [MEDICATION NAME] especially at night for sleeping because he had sundowners and gets very anxious in the evenings. DON indicated the doctor felt it was working, and the resident needs this to help calm him down in the evening so he can sleep. The DON indicated he ruminated and had Dementia. Queried as to he has no [DIAGNOSES REDACTED]. CARE PLAN: with updated date of 9/24/14 indicated: Potential for drug related complications associated with use of [MEDICAL CONDITION] medications related to anti- anxiety and anti- depressant medication Goal: will be free of [MEDICAL CONDITION] drug related complications Interventions: Access for pain Monitor for side effects of anti anxiety/ hypnotic and report to physician Monitor for side effects of anti-depressant and report to physician Pharmacy review of drug regimen Provide medications as ordered by physician and evaluate for effectiveness [MEDICAL CONDITION] medication risk/benefit and reduction plan as recommended by Physician and pharmacist The record lacked a plan of care to identify the type of behavior the resident exhibited for use of an antipsychotic medication or interventions to be provided when the resident exhibited any behaviors. On 10/19/15 at 8:15 a.m. a policy was received by the Medical Records Staff titled Clinical Services- Resident Behaviors dated 2/10/15 indicated to develop behavior care plans and medication regimens, to optimize the function abilities of residents while monitoring for adverse side effects and improved behaviors. The Licensed nursing staff completes the Plan of Care following identification of antipyschotic medication usage or behavior concerns. 4. During an observation on 10/5/15 at 9:13 a.m., Resident #117 was observed to be sleeping in bed. During an observation on 10/5/15 at 12:24 p.m., Resident #117 was observed to be transferred from a recliner with assist of 2 persons. Resident #117 made no attempt at speech. Resident #117 was observed to be assisted with her lunch. The clinical record for Resident #117 was reviewed on 10/7/15 at 7:44 a.m. Resident #117 had diagnosed including: [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 8/13/15, indicated Resident #117 had severed cognitive impairment and was a Level II with mental [MEDICAL CONDITION] and serious mental illness. A Preadmission Screening and Resident Review (PASRR), dated 7/24/15, indicated Resident #117 was developmentally disabled and had a mental illness. The PASRR included the following recommendations for Resident #117: 1. Resident #117 might benefit from continued routine healthcare services with her primary care physician, dentist, ophthalmologist, and audiologist, Resident #117 might benefit from an appointment with a neurologist related to reported tardive dyskinesia behaviors. 2. Resident #117 might benefit from assistance with maintaining family contact while away from home. 3. Resident #117 might benefit from long term care services at a nursing facility related to the exacerbation of her neurocognitive disorder . 4. Resident #117 would benefit being placed in a facility near her family as requested by the power of attorney and sister, so that her family can visit and actively participate in her care 5. Resident #117 might benefit from a behavior support plan with interventions listed for her various behaviors. The clinical record lacked a care plan for Resident #117's developmental disabilities and discharge planning. During an interview on 10/13/15 at 1:48 p.m., the Social Worker (SW) indicated the dementia care unit director did the care plans for residents on the dementia care unit. During an interview on 10/14/15 at 4:05 p.m., the Staff #1 indicated the family had been having difficulty with finding another facility close to their home for the resident due to past behaviors of the resident. The dementia care unit indicated she was unaware the clinical record lacked a care plan for Resident #117. 3.1-35(a)
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prepare and allow participation by the resident and responsible party a comprehensive care plan for 2 of 35 residents reviewed for care planning conferences. (Resident #16, Resident A) Findings include: 1. During a family interview on 10/6/15 at 10:07 a.m., Resident #16's family member indicated the family had not been invited to a care conference for the resident. The family member indicated they were notified when Resident #16 had a change in medications or treatments but had never been invited to a care conference for the resident. The clinical record for Resident #16 was reviewed on 10/8/15 at 1:44 p.m. Resident #16 had clinical [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment, dated 8/7/15, indicated Resident #16 had a BIMS (Brief Interview for Mental Status) assessment score of 3, indicating severe cognitive impairment. The clinical record lacked documentation of a care conference for Resident #16. 2. During an interview on 10/5/15 at 3:32 p.m., Resident A indicated he did not remember the last time he had a care planning conference. Resident A indicated he was not told when he had a medication or treatment changed.

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) The clinical record for Resident A was reviewed on 10/13/15 at 11:39 a.m. A quarterly MDS (Minimum Data Set) assessment, dated 6/25/15, indicated there resident participated in the MDS assessment. Resident A had a BIMS (Brief Interview with Mental Status) assessment score of 15, indicating no cognitive impairment. The clinical record lacked any documentation of a care conference for Resident A. During an interview with the Social Worker (SW), on 10/14/15 at 2:54 p.m., the SW indicated she did not remember when Resident #16 or Resident A had their last care conferences or if any family members attended. The SW indicated she would get the schedule of care conferences from the MDS Coordinator. The SW indicated the MDS Coordinator usually informed the residents and/or their families or responsible parties of upcoming care conferences. During an interview with the MDS Coordinator on 10/14/15 at 3:20 p.m., the MDS Coordinator indicated she informed the SW of the care conferences but the SW was supposed to notify the residents and/or their families or responsible parties. The MDS Coordinator indicated often the facility would not have care conferences for the residents as the families normally would just stop by the office if there was a problem. She further indicated the dementia care unit director did the scheduling for the dementia care unit. A policy titled, Social Services, effective 2/26/15 and obtained from the Adm (Administrator) on 10/19/15 at 7:45 a.m., indicated the resident/legal representative would be notified prior to each interdisciplinary care plan meeting, encouraged to attend, and solicit their input. The policy indicated the family would be invited with the resident's/legal representative's permission. The policy further indicated if the legal representative was unable to attend, the care plan would be reviewed with the resident, legal representative, and family, if appropriate, and their responses would be documented. 3.1-35(c)(2)(C)
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supported body positions. Residents were not positioned and supported while in bed for 2 of 3 residents reviewed for positioning. (Resident I, Resident U) Findings include: 1. On 10/8/15 at 9:28 a.m., Resident I was observed sleeping in bed. Resident I's head was unsupported and leaning to the left. On 10/13/15 at 8:56 a.m., Resident I was observed lying in bed. Resident #I indicated she was uncomfortable. On 10/13/15 at 4:01 p.m., Resident I was observed lying sideways in bed with her legs and head almost out of bed. On 10/13/15 at 4:08 p.m., Resident I's clinical record was reviewed. Resident I's Quarterly MDS (Minimum Data Set) Assessment, dated 9/22/15, indicated Resident I required extensive assistance of 2 people for bed mobility. The Care plans included, but were not limited to: I have a physical functioning deficit, initiated on 8/19/15. The interventions included, but were not limited to, bed mobility assistance of one. On 10/14/15 at 8:52 a.m., Resident I was observed in bed leaned over the left without a pillow. Resident I indicated she was uncomfortable. On 10/14/15 at 12:52 p.m., the DON indicated Resident I was selectively dependent for care. 2. On 10/5/15 at 2:16 p.m., Resident U was observed lying in bed. Resident U's head was unsupported and leaning. On 10/14/15 at 11:05 a.m., Resident U's clinical record was reviewed. Resident U's [DIAGNOSES REDACTED]. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/17/15, indicated Resident U required extensive assistance of 2 persons for bed mobility. On 10/15/15 at 10:48 a.m., Resident U was observed to be leaning to the left and unsupported while lying in bed. Resident U indicated he was uncomfortable. The Care Plans included, but were not limited to, I have a physical functioning deficit, initiated on 8/19/15. The interventions included, but were not limited to, bed mobility assistance of two. On 10/15/15 at 2:00 p.m., LPN #1 indicated Resident U was dependent for care. This Federal tag relates to Complaint IN 592. 3.1-38(b)(6)
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide showers and oral hygiene to 3 of 3 residents reviewed for ADL (Activities of Daily Living) and 1 of 3 residents reviewed for choices in a total sample of 39 residents on stage II. (Resident A, Resident G, Resident I, Resident B) Findings include: 1. During an interview on 10/5/15 at 4:09 p.m Resident A indicated he had not received a shower at times and never get his teeth brushed. Resident A's teeth were observed to be yellow. During an observation on 10/8/15 at 10:43 a.m., Staff #3 was observed to be combing Resident A's wet hair. Resident A indicated he had received a shower. Resident A's teeth were yellow. After combing the resident's hair and applying clean clothes to the resident, CNA #3 and CNA #4 placed the resident onto his power scooter and left the room. Resident A indicated he had not had any oral care provided. The clinical record for Resident A was reviewed on 10/13/15 at 11:39 a.m. The clinical record indicated Resident A had [DIAGNOSES REDACTED]. The Shower Schedule for Resident A was obtained from Staff #3 on 10/14/15 at 10:00 a.m. The schedule indicated Resident A was to receive a shower twice a week on the day shift. During review of the ADL (Activity of Daily Living) documentation on 10/14/15 at 11:45 a.m., the ADL log dated 8/14/15 through 10/13/15, indicated Resident A missed 6 of 16 showers. During an interview on 10/13/15 at 2:36 p.m., CNA #3 indicated morning care included giving the resident a bath, hair care, oral care, skin care, pericare, et cetera. CNA #3 indicated Resident A should receive oral care every day. CNA #3 further indicated oftentimes she would not be able to finish the care she needed to do for a resident as the nurse would have her leave the resident she was caring for and go to another resident's room for something. A policy titled, Partial Bath, effective 1/26/15, and obtained from the Adm (Administrator) on 10/19/15 at 7:45 a.m., indicated the care of fingernails was part of the bath and ensure the nails are clean. 2. On 10/8/15 at 9:30 a.m., Resident G indicated he received showers on Tuesday and Thursday evenings. On 10/8/15 at 12:43 p.m., Resident G's clinical record was reviewed. Resident G's [DIAGNOSES REDACTED]. The CNA Assignment sheet indicated Resident G was to receive a shower on Wednesday and Saturday evenings. The 14 Day MDS (Minimum Data Set) Assessment, dated 9/22/15, indicated Resident G required extensive assistance of one person for personal hygiene and was totally dependent on one person for bathing. On 10/15/15 at 9:10 a.m., the DON indicated Resident G could not have a shower related to his surgical wound. On 10/15/15 at 9:17 a.m., the ADON was interviewed. The ADON indicated Resident G had a critical hip replacement and they were afraid to move him too much. The ADON indicated she felt if they transferred the resident they might have damaged his hip. On 10/15/15 at 11:30 a.m., Resident G's hospital records and consultations were reviewed. The Consultations indicated Resident G had been weight bearing as tolerated since 9/22/15 The Bathing Type Detail Report indicated between 9/14/15 and 10/9/15, Resident G missed 7 of 8 showers.

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) 3. On 10/5/15 at 10:58 a.m., Resident B was observed with a brown substance underneath untrimmed fingernails with chipped nail polish. 4. On 10/13/15 at 4:01 p.m., Resident I was observed with a brown substance underneath untrimmed fingernails. This Federal tag relates to Complaint IN 592. 3.1-38(a)(2)(A) 3.1-38(a)(3)(C) 3.1-38(b)(1)
F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide range of motion services for 2 of 2 residents reviewed with contractures for range of motion services. (Resident U, Resident V) Findings include: 1. On 10/5/15 at 2:15 p.m., LPN #1 indicated Resident U had a contracture of the left hand. On 10/14 15 at 10:42 a.m., Resident U was observed lying in bed. On 10/14/15 at 11:05 a.m., Resident U's clinical record was reviewed. Resident U's [DIAGNOSES REDACTED]. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/17/15, indicated Resident U had physical functional impairment on both of his upper and lower extremities. On 10/14/15 at 3:02 p.m., the DON indicated Resident U had been on a restorative program for range of motion. The DON further indicated Resident U no received range of motion from the CNA's during daily morning care. On 10/14/15 at 3:13 p.m., CNA #1 and CNA #2 were interviewed. They indicated Resident U received range of motion services through the restorative aid. On 10/15/15 at 9:09 a.m., CNA #3 indicated she had just begun to provide restorative range of motion services on the day before (10/14/15). On 10/19/15 at 7:45 a.m., the Administrator provided the Restorative Guideline policy, dated, 2/20/15. The policy included, but was not limited to, Indicators for selection may include, but are not limited to: A [DIAGNOSES REDACTED]. 2. On 10/15/15 at 3:42 p.m., Resident V was observed lying in bed. He was able to move his left arm up in the air upon request, but unable to move his right arm up in the air upon request. On 10/13/15 at 12:23 p.m., during record review of Resident V, the Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had no impairments of upper or lower extremities. The Quarterly MDS dated [DATE] indicated the same. The 14 day MDS dated [DATE], also indicated no impairments of the upper or lower extremities. A progress note dated 8/28/15 indicated Resident V was recently on Physical Therapy and Occupational Therapy caseload for wheelchair positioning and contracture management. discharged from services 1 week ago. A nursing note dated 8/26/15 indicated to ask the family to provide some stretchy clothes for the resident, pants, sweatshirts, socks. The ones he currently had are difficult to fit over his increasing contractures. Nursing notes dated 5/6/15 indicated resident is incontinent of bowel and bladder, contracted, and requires total care with activities of daily living, positioning in bed, fed by staff. Program notes dated 8/31/15 indicated recently received Physical therapy, Occupational therapy ., and no further decline in contractures noted . will discontinue program at the time, will re-evaluate for further programming at later date. On 10/15/2015 at 3:39 p.m., Registered Nurse #1 indicated Resident V had a contracture to his right arm, and was no longer receiving therapy. On 10/14/15 at 12:51 p.m., during an interview with the MDS Coordinator (Minimum Data Set), she indicated that she had her own worksheet where she kept track of contractures. She indicated that she did not code the MDS for contractures if they did not impede a residents daily living, or put them at risk for injury. She indicated this was her interpretation of the MDS. She indicated Resident V usually does not feed himself, and at times can drink on his own. On 10/15/15 at 3:24 p.m., the MDS Coordinator indicated there was no Passive Range of Motion program for Resident V for September and October 2015, and that no documentation was being done for Passive Range of Motion . She indicated there was no place in the computer program for the certified nursing aides to document range of motion. On 10/15/15 at 3:02 p.m., the Director of Nursing indicated that once a resident was off therapy, they need to be on a program for restorative or range of motion if they have contractures. This Federal tag relates to Complaint IN 592. 3.1-42(a)(2)
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents environment was free from accidents. The space between the residents side rails and mattress was too great of 1 of 35 residents reviewed during Stage 1 of the survey. (Resident I) Findings include: On 10/5/15 at 11:03 a.m., Resident I was observed lying in bed. A space between the mattress and side rail was observed to be greater than 5 inches. On 10/13/15 at 8:56 a.m., Resident I was observed lying in bed. A space between the mattress and side rail was observed to be greater than 5 inches. On 10/13/15 at 4:01 p.m., Resident I was observed lying in bed. A space between the mattress and side rail was observed to be greater than 5 inches. On 10/13/15 at 4:08 p.m., Resident I's clinical record was reviewed. Resident I's [DIAGNOSES REDACTED]. Resident I's Quarterly MDS (Minimum Data Set) Assessment, dated 9/22/15, indicated Resident #I required extensive assistance of two people for bed mobility. On 10/13/15 at 4:31 p.m., the DON was interviewed. The DON indicated there was too much space between the mattress and side rails. The DON indicated the side rails would be fixed immediately. On 10/19/15 at 7:45 a.m., the Administrator provided the Bed Rail Guideline policy, dated 9/29/15. The policy included, but was not limited: Assessment is completed to identify potential benefits from utilizing bed rails and minimize risks The assessment and documentation also includes: measuring the gaps between the rail(s) themselves and the gaps between the bed-rail and the mattress. A visual review is performed to assess that the mattress does not shift/slide allowing for an increased gap between the bed and the bed rail. 3.1-45(a)(1)
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for nebulizer

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F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) treatments received the proper care. The nurse did not assess the resident prior to the administration, midway through the administration, or stay with the resident while they were receiving the nebulizer treatment. (Resident #6) Findings include: During an observation on 10/14/15 at 8:59 a.m., Resident #6 was observed to receive a nebulizer treatment. Staff #2 was observed to enter the resident's room and obtained the nebulizer equipment. Staff #2 was observed to place the medication into the machine, place the nebulizer mask over the resident's face and turn the nebulizer on. Staff #2 left the room after informing the resident she would be back in a few minutes. Staff #2 indicated she sets her watch for 5 minutes so she could check on the resident. Staff #2 continued to pass medications to other residents. After 10 minutes, Staff #2 reentered Resident #6's room, turned the nebulizer off, and remove the nebulizer mask from Resident #6. Staff #2 was observed to listen for the resident's breath sounds, and obtained the resident's pulse and respirations. During an interview on 10/14/15 at 9:05 a.m., Staff #2 indicated she needed to assess the resident midway through the nebulizer treatment. A policy titled Oral Inhalation Administration, dated 05/12 and obtained from the Director of Nursing on 10/15/15 at 3:33 p.m., indicated a baseline pulse, respiratory rate and lung sounds should be obtained prior to starting the nebulizer treatment and approximately 5 (five) minutes after the treatment has begun the resident's pulse should be obtained unless if clinical judgment indicates the pulse should be obtained sooner. The policy further indicated the nurse should remain with the resident for the treatment unless the resident had been assessed and authorized to self-administer. 3.1-47(a)(6)
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide adequate indications for psychoactive medications for 3 of 6 residents in a total sample of 35 residents reviewed for unnecessary medications. Resident's with no behaviors received psychoactive medications, a resident had a physician's orders [REDACTED]. (Resident #32, Resident #53, Resident D) Findings include: 1. During an observation on 10/5/15 at 3:34 p.m., Resident #32 was observed to be sitting in a chair in the activity room listening to music. The clinical record for Resident #32 was reviewed on 10/8/15 at 11:50 a.m. Resident #32 had clinical diagnosed including: [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 8/16/15, indicated Resident #32 had a BIMS (Brief Interview for Mental Status) assessment score of 2, indicating severe cognitive impairment. The MDS indicated Resident #32 had no behaviors exhibited. Resident #32 had a physician's orders [REDACTED]. A pharmacy request, dated 8/18/15, requested [MEDICATION NAME] 2.5 mg be considered for a GDR (Gradual Dose Reduction) to 50% of current dose with the goal of discontinuation. The request was accepted with the directions to revise orders as suggested and as directed. The clinical record lacked documentation the medication was reduced. Resident #32 had a physician's orders [REDACTED]. The clinical record lacked documentation of any behaviors since 7/16/15. During an interview on 10/15/15 at 4:00 p.m., Staff #1 indicated she did not know why the resident had not had a gradual dose reduction for the [MEDICATION NAME] or [MEDICATION NAME]. She indicated the [MEDICATION NAME] was discontinued on 10/9/15. 2. During an observation on 10/4/14 at 9:15 a.m., Resident #53 was observed to be sitting in the activity room in a wheelchair holding a doll. The clinical record for Resident #53 was reviewed on 10/8/15 at 2:09 p.m. Resident #53 had diagnosed including: [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 6/27/15, indicated Resident #53 had a BIMS score of 1, indicating severe cognitive impairment. The MDS further indicated the resident had not exhibited any behaviors. A behavior log, dated 7/16/15 through 10/13/15, indicated Resident #53 had had no behaviors. Resident #53 had a physician's orders [REDACTED]. During an interview with the dementia unit director on 10/15/15 at 4:00 p.m., Staff #1 indicated Resident #53 had not had any psychotic behaviors recently. 3. On 10/7/15 at 9:23 a.m., record review of Resident D was done which indicated the resident had the following diagnoses that included, but not limited, pneumonia, [MEDICAL CONDITION], dementia, anxiety,major [MEDICAL CONDITION], Parkinson, paralysis agitans, [MEDICAL CONDITION] bladder, [DIAGNOSES REDACTED], and generalized anxiety disorder. On 10/7/15 9:23 a.m., the clinical chart review for medications included, but not limited to: [MEDICATION NAME] (anti-psychotic) 150 mg by mouth at bedtime- related to [MEDICAL CONDITION] order on 4/13/15- Changed from [MEDICATION NAME] (anti-psychotic) On 5/1/15, Behavior Health Progress Note: resident had no behavior - had [MEDICAL CONDITION]/ anxiety On 6/26/15, a Behavioral Health Progress Note indicated Resident D had [MEDICAL CONDITION]/ anxiety- no behaviors. On 8/7/15 Behavior Health Progress note indicated resident worries, also Resident D had changed [DIAGNOSES REDACTED]. Review of monthly gradual dose reduction was done for [MEDICATION NAME]. On 2/3/14, a psychiatric evaluation was done which indicated the resident wanted to go home and became angry and verbally aggressive with wife on phone in the evening. Resident D was tearful at times. Resident feeling depressed, had decreased energy, denied wanting to die or commit suicide. Worried excessively about wife. Resident D is anxious and worries about wife and kids, depressed and crying. [DIAGNOSES REDACTED]. Recommend [MEDICAL CONDITION] medication management. The nursing notes indicated the following behaviors since 1/1/15: On 9/6/15 at 17:08 p.m,. the Resident D was playing cards with other residents. Another resident picked up a card, in which Resident D became agitated and punched the other resident in the stomach with his hand/fist. Resident D was asked what happened and this resident could not remember or chose not discuss the event, making random statements that were almost nonsensical and denied any happenings Residents daughter was notified and resident was placed on 15 min checks for 72 hours to assure continued safety and stability An incident report was made out for the incident. On 10/12/15 at 4:01 p.m., notes indicated the resident had made a derogatory comment to a resident. He told the resident to get the f*** out of here. He also had called another person a tattletale. The resident was noted to be sitting in his room quietly throughout the day or in the activity room playing cards. On 9/13/15, the MDS (Minimum Data Set) Assessment indicated Resident D had no behaviors. On 10/7/15 at 3:18 p.m., an interview with Social Services about behaviors of Resident D. She indicated, the resident had dementia secondary to [MEDICAL CONDITION], and was probably a candidate for the Alzheimer's unit. She indicated Resident D's behaviors were, agitation, abrupt with answers, very nervous and cries about wanting to go home to his wife. SS indicated Resident D was involved in an incident playing cards , Resident D went to stop another resident from taking his card and with open hand fist they each punched each other in the stomach. SS indicated there were no behavior tracking sheets, all behaviors were charted in the nursing notes and then reviewed the next day during daily meetings. SS indicated Resident D has had no behaviors except for one the other day. On 10/14/15 at 1:54 p.m., interview with SS indicated they do not have a tracking log and all acute behaviors are documented in nurses notes, then the next morning the IDT(interdepartmental team) meets and talks about the behavior. If behaviors were more frequent and/ or severe by checking nurses notes every day, they contacted the physician and /or pharmacy about any needed change in medications. On 10/15/15 at 12:13 p.m. an interview with DON (Director of Nursing) indicated Resident D needed the [MEDICATION NAME] especially at night for sleeping because he had sundowners and became very anxious in the evenings. The DON indicated the doctor felt it was working, and the resident needs this to help calm him down in the evening so he could sleep. The DON

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) indicated he ruminated and had Dementia. Queried as to he has no [DIAGNOSES REDACTED]. On 10/19/15 at 8:15 a.m., a policy dated 12/2/14, titled Resident Behaviors, was received from Medical Records Staff which indicated, but not limited to: The physician orders [REDACTED]. Review of the Care Tracker Mood and Behavior Report form care tracker Updated care plan with current medication and behaviors identified along with resident specific approaches. 3.1-42(a)(2) 3.1-48(a)(4)
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet the needs of residents for 3 of 5 units reviewed for staffing, 5 of 5 staff members interviewed, and 5 of 25 residents interviewed and 1 of 3 family members interviewed. Residents were not given showers as ordered, residents were unkept, nails were unclean and untrimmed, and water was not provided daily. (Dementia unit, 400 unit, 500 unit, Staff #4, Staff #2, Staff #3, Resident A, Resident B, Resident C, Resident D, Resident E) Findings include: 1. During an observation on 10/5/15 at 4:09 p.m., Resident A was observed to have yellow teeth. During an interview on 10/13/15 at 2:20 p.m., Resident A indicated he was to receive a shower twice a week but oftentimes it did not happen. Resident A indicated the unit was often short staffed and several of the residents did not receive their showers. 2. During an observation on 10/5/15 at 10:58 a.m., Resident B was observed to have dirt under the fingernails, nail polish was chipped, and the nails needed to be trimmed. During an interview, Resident B indicated she needed to have her nails trimmed but the staff is oftentimes short and unable to do them. 3. During an observation on 10/8/15 at 10:28 a.m., Resident C was observed to be dressed and lying in bed. Resident C's nail were long and untrimmed with dirt under his nails. Resident C was observed to be wearing jeans with holes in them and his hair was greasy and disheveled. The same was observed on 10/14/15 at 3:45 p.m. 4. During an interview on 10/14/15 at 9:50 a.m., Resident D indicated he was receiving a shower approximately 2 (two) weeks ago when a nurse entered the shower room and instructed the CNA to assist another resident. Resident D indicated the nurse stood in the shower room until the CNA returned and finished his shower. Resident D indicated the nurse did not assist with his shower and even though he was covered with a bath blanket, he was cold. Resident D further indicated he usually had to ask for fresh ice water as the staff did not have time to pass it. 5. During an interview on 10/14/15 at 10:00 a.m., Resident E indicated the facility was often short staffed. Resident E indicated she would often have to remain in bed until 3:00 p.m. or later waiting to be transferred from her bed to her power scooter. She indicated the unit often would have 1 (one) CNA working on the day shift on the unit. She indicated all the shifts were short staffed. 6. During an interview on 10/13/15 at 2:36 p.m., Staff #4 indicated she was giving Resident D a shower a couple of weeks ago when she was instructed by LPN #2 to take Resident A out to smoke. Staff #4 indicated LPN #1 stayed in the shower room with Resident D but did not bath the resident. Staff #4 indicated she is the only CNA on the 400 unit. Staff #4 indicated she usually had to help 500 unit as the 500 unit resident's required a lot more care and the unit had only 1-2 staff members during the day. 7. During an interview on 10/14/15 at 10:23 a.m., Staff #2 indicated the facility is frequently short staffed. She indicated there had been 1 CNA for 18 (eighteen) residents at times. Staff #2 indicated when Resident A would request to smoke, the CNA would have to escort him outside. Staff #2 indicated Resident A would usually be outside for 40 minutes or longer with the CNA in attendance. Staff #2 indicated this would happen 5-6 times a day. Staff #2 further indicated she has seen an increase in pressure wounds on the residents due to the lack of staff. Staff #2 indicated frequently there were 2 CNAs for the 400 and 500 units during the day and evening and only 1 CNA on the night shift. Staff #2 indicated the facility would often use hospitality aides to assist the staff but the hospitality aides could only pass trays, pass water, and answer call lights. Staff #2 indicated the hospitality aides were not able to give any resident care. Staff #2 indicated the hospitality aides were normally staffed from the ancillary departments. 8. During an interview on 10/14/15 at 11:45 a.m., Staff #3 indicated the units are frequently short staffed. Staff #2 indicated the staff oftentimes were not able to take their lunch and would get a warning if they were unable to take their lunch. Staff #3 indicated the staff were not able to do resident care as it should be done due to lack of staff. 9. During an interview on 10/13/15 at 1:40 p.m., a family member indicated the day shift staff were overwhelmed as they had too much work to do and the night shift staff were non-existent. 10. During an interview on 10/15/15 at 3:00 p.m., the DON (Director of Nursing) indicated the facility was short staffed. The DON indicated the facility had not been able to hire a lot of staff as the facility had not had many applicants. The DON further indicated the location of the building made possible applicants not want to apply. A job description titled, Aide Hospitality, obtained on 10/19/15 at 9:52 a.m., from the Medical Records person, indicated the job duties included the following: Cleaning patient and equipment and resident's personal care and grooming items per established procedure Ensure residents closets, bedside stands, drawers, and closets are clean, orderly, and odor free Complete admission inventory of clothing and belongings including labeling Distribute personal laundry Monitor and replenish resident care articles Answer call lights and provide non-care giving tasks Relay requests for actual care assistance to nursing staff Transport residents to meals, activities, care conferences Assist with passing trays in the dining room and to resident who do not require feeding assistance The facility lacked a policy for staffing and assignments. This Federal tag relates to Complaint IN and IN 502. 3.1-17(a)
F 0354 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Use a registered nurse at least 8 hours a day, 7 days a week.** Based on record review and interview, the facility failed to provide the services of a registered nurse for at least 8 consecutive hours a day. 7 days a week for 6 of 153 days reviewed. (5/2/15, 6/6/15, 8/29/15, 9/12/15, 9/13/15, and 9/27/15) Findings include: The Daily Staffing Plan was obtained from the DON (Director of Nursing) on 10/14/15 at 4:00 p.m. The staffing plans included the dates from May 1, 2015, through September 30, 2015. The Daily Staffing Plan indicated the following: 1. On May 2, 2015, the facility did not have registered nurse coverage for an entire 24 hour period. 2. On June 6, 2015, the facility had registered nurse coverage for 2 hours in a 24 hour period, from 9:00 a.m. through 11:00 a.m. 3. On August 29, 2015, the facility did not have a registered nurse for the entire 24 hour period. 4. On September 12, 2015, the facility had a registered nurse on duty for 4 hours, from 7:00 p.m. through 11:00 p.m., for the 24 hour period. 5. On September 13, 2015, the facility had a registered nurse on duty for 4 hours, from 7:00 p.m. through 11:00 p.m., for the 24 hour period. 6. On September 27, 2015, no registered nurse was on duty for the entire 24 hour period. During an interview with the DON on 10/15/15 at 4:34 p.m., the DON indicated the Daily Staffing Plan was complete. The DON

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	155248	A. BUILDING _____ B. WING _____	10/19/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRENTWOOD	30 E CHANDLER AVE EVANSVILLE, IN 47713

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 0354 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) indicated she thought the facility had the coverage daily. The facility lacked documentation of a policy for registered nurse coverage. This Federal tag relates to Complaint IN 592 and IN 502. 3.1-17(b)(3)
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** Based on observation, interview, and record review the facility failed to ensure food was prepared and served in a sanitary manner, for 2 of 2 kitchen observations. Findings include: 1. On 10/5/15 at 9:02 a.m., during an observation of the kitchen, the floor was observed to be sticky and have dirt and debris build up in the dry storage room. The wooden door to the dry storage room had dirt built up on the bottom, and the floor around the base of the door had dirt and debris built up. The same was observed on 10/13/15 at 8:53 a.m. 2. On 10/5/15 at 9:10 a.m., the tray line was observed to have a brown substance built up on the walls in the water wells, and around the edges of the wells. The same was observe on 10/13/15 at 8:56 a.m. 3. On 10/5/15 at 9:00 a.m., the doors leading into the kitchen were observed to have peeling paint and black marring on the bottom half of the doors. The same was observed on 10/13/15 at 8:49 a.m. 4. During an observation of dining on 10/5/15 at 12:20 p.m., the Payroll clerk was observed to wash her hands for 10 seconds, then touch the faucet with her bare hand to turn the water off. 5. During an observation on 10/5/15 at 11:15 a.m., CNA #9 was observed to obtain a cup of ice for Resident #25 and place it on the table in front of him by the rim of the cup without performing any hand hygiene. CNA #9 was observed to type on a computer, obtain and clean Resident #28's glasses and return them to the resident prior to sanitizing her hands. At 11:50 a.m., CNA #9 was observed to move Resident #28 to the dining room table, place her hands in her pocket and obtain her phone and place her hands back into her pockets. CNA #9 was then observed to move her glasses up on her face. CNA #9 was observed to remove 2 (two) wheelchairs from the library area and place them in the lounge area. CNA #9 assisted with the transfer of Resident #56 into one of the wheelchairs at 11:54 a.m. CNA #9 was then observed to obtain the dessert pan and place it on the kitchen countertop. At 12:15 p.m., CNA #9 was observed to assist Resident #117 into a wheelchair. CNA #9 was observed to move Resident #117 to the dining room table, obtained a chair for herself, and began to feed Resident #117. On 10/15/15 at 1:58 p.m., during an interview, the Dietary Manager indicated the tray line was cleaned on Thursday and Saturdays by the evening cook. She also indicated there was a cleaning schedule for the kitchen, which staff signs when the cleaning task was completed. On 10/19/15 at 10:27 a.m., during an interview, the Payroll clerk indicated that the procedure for hand washing was to turn on the water, apply soap, wash hands, get a paper towel and turn off the water. The Business Manager indicated to wash hands for 30 seconds. On 10/15/15 at 2:25 p.m., the Dietary Manager provided a cleaning schedule for the kitchen. On 10/19/15 at 7:45 a.m., the Administrator provided a policy on hand washing. The policy indicated to wash hands for a minimum of 20 seconds, and to turn off faucets with a clean, dry cloth. 3.1-21(i)(2) 3.1-21(i)(3)
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were labeled with open dates and discarded upon discharge according to policy for 4 of 5 units. (Dementia Unit, 200 Unit, 400 Unit, 500 Unit) Findings include: 1. During an observation of the dementia unit on [DATE] at 11:00 a.m. the following were observed: Resident B had Timolol Ophthalmic drops 0.5% with an open date of [DATE]. During an interview on [DATE] at 11:05 a.m., LPN #3 indicated eye drops should be discarded 30 (thirty) days after opening. A box of Risperdal Concerta (an antipsychotic medication) 25 (twenty-five) mg (milligram) IM (intramuscularly) for Resident #74 was observed to be in the refrigerator. LPN #3 indicated the resident had expired on [DATE]. An open vial of Tuberculin Skin Test solution had an open date of [DATE]. LPN #3 indicated the medication should have been discarded 30 days after opening the vial. 2. During an observation of the 200 Unit on [DATE] at 11:14 a.m., the following were observed: Resident #48 had an open container of Omeprazole (an antiulcer medication) 2 mg/ml (milliliter) with no open date on it. Resident #37 had an container of Omeprazole 2 mg/ml (milliliter) with no open date on it. Resident #107 had an bottle of Debrox Otic Solution 6.5% with no open date on them. An open bottle of Flulaval (an influenza vaccine) was observed in the medication room refrigerator with and expiration date of ,[DATE] on it. 3. During an observation of the 400 unit on [DATE] at 11:30 a.m., the following were observed: Resident #A had a bottle of Nitrostat 0.4 mg sublingual. The bottle indicated to the Nitrostat was to be discarded after [DATE]. 4. During an observation of the 500 Unit on [DATE] at 11:40 a.m., the following were observed: Resident #43 had an open bottle of Latanoprost Ophthalmic Solution 0.005% open with no open date. Resident #114 had a Lantus Insulin Kwikpen with an open date of [DATE]. The manufacturer's recommendation indicated the insulin was to be discarded after 28 (twenty-eight) days. Resident #G had 2 boxes of Glucagon Injectable (a medication used for [DIAGNOSES REDACTED]) in the medication refrigerator. The resident was discharged on [DATE]. Resident #31 had a 2-pack Epipen in the medication refrigerator. Resident # was discharged on [DATE]. Resident #44 had an open hand held Proair inhaler with no open date on it. Resident #94 had an open hand held Proair inhaler with no open date on it. During an interview on [DATE] at 11:10 a.m., LPN #3 indicated if a resident expires, the night shift nurse is responsible for preparing the medications to send back to the pharmacy. LPN #3 further indicated when a medication is opened, it is to be dated with the date it is opened. During an interview on [DATE] at 11:35 a.m., LPN #1 indicated eye drops are good for 60 (sixty) days after opening the bottle and inhalers are good for 1 year after opening them. LPN #1 indicated she originally thought eye drops were only good for 30 days after they were opened. During an interview on [DATE] at 11:46 a.m., LPN #2 indicated Levimir insulin was good for 42 days after opening and all other insulins were good for 30 days after opening. A policy titled, Storage of Medications, dated ,[DATE] and obtained from the Administrator on [DATE] at 7:45 a.m., indicated medications were to be stored safely, securely, and properly, following manufacturer's recommendations . 3XXX,[DATE](j)(k)(l)
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure infection control procedures for 4 of 7 residents observed receiving care, glove changes and handwashing was not performed during the care. (Resident F, Resident K, Resident J, Resident I) Findings include:

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) 1. On 10/7/15 at 9:57 a.m., a dressing change by Staff #3 was observed. Staff #3 washed their hands, donned gloves, and then removed dressing on left hip which was saturated with green drainage. Staff #3 took off his gloves and donned new gloves. No handwashing was completed. Staff #3 cleaned area along Resident F's hip suture line with a wash cloth and patted the area dry. Staff #3 donned another set of gloves with no handwashing performed and proceeded to put new Band-Aid on area. Staff #3 then put the old dressing in trash bag, removed the gloves, and took trash out of room and washed hands. On 10/14/15 at 9:46 a.m., Staff #3 was observed to change the dressing for Resident F. Staff #3 donned gloves, took off the bandage, which had a small amount of green-yellow drainage, and cleaned site with 2 different wet wash clothes, without changing gloves or washing their hands. Staff #3 blotted the incision area dry and placed clean dressing on hip area. Staff #3 took off his gloves and removed dirty linen. CNA #4 was observed on 10/14/15 at 9:55 a.m., was cleaning stool from resident F. CNA #4 had on gloves, used two wet washcloths, and cleaned rectum, the buttocks area, and wiped area dry with a dry washcloth. CNA #4 obtained a clean brief and put on Resident F. CNA #4 did not change gloves between cleaning and drying and putting on brief. 2. On 10/14/15 10:05 a.m., Staff #3 was observed doing a dressing change on the left shoulder of Resident K. The DON (Director of Nursing) was also in room observing dressing change as well. Staff #3 washed his hands, gloved, peeled off the dressing from left shoulder area. Staff #3 changed his gloves, no handwashing was done. Staff #3 proceeded to cleanse area on left shoulder with wound cleaner. Staff #3 reached in pocket and obtained scissors and cut to size an antibiotic dressing. Staff #3 then dropped the sterile antibiotic dressing on the floor. Staff #3 obtained another part of the antibiotic dressing left in package, which was cut to size with scissors he obtained from his pocket. Staff #3 then placed another dressing on the left shoulder wound. Staff #3 bagged the dirty gloves, dressing, packaging and discarded them. Staff #3 then washed his hands. On 10/14/15 at 10:20 a.m, an interview with Staff #3 queried if handwashing should be done between removing old dressing, cleaning and applying new gloves and dressing. He stated he believed so but he needed to check the policy. On 10/14/15 2:06 p.m., an interview with DON regarding any concerns with handwashing while Staff #3 changed the dressing on Resident K. The DON indicated she thought he was very nervous and fumbled around. Queried as to whether his handwashing between clean and dirty was following facility policy, DON said no. On 10/14/15 at 3:11 p.m., the DON brought in an inservice sheet which indicated she had inserviced the RN's, LPN's, and CNA 's whom were working today on clean dressing change and handwashing. 3. During an observation on 10/8/15 at 10:43 a.m., Staff #4 was observed to be combing Resident A's hair. Staff #4 did not have any gloves on. CNA #2 entered the resident's room and applied gloves. Staff #4 applied gloves after CNA #2 entered the room. After combing the resident's hair, Staff #4 removed her gloves and left the room to obtain clean linens. Staff #4 placed a draw sheet on Resident A's bed and Staff #4 and CNA #2 transferred Resident A into bed with the assist of a Hoyer lift. Staff #4 assisted the resident to turn onto his right side and Staff #4 applied a barrier cream to the resident's rectal area, obtained a clean brief, and placed it under Resident A's buttocks. Resident A was assisted to turn to the left side. CNA #2 removed her gloves, washed her hands for 5 seconds, and reapplied clean gloves. Staff #4 and CNA #2 assisted Resident A onto a power scooter. Staff #4 and CNA #2 removed their gloves and washed their hands for 7 seconds. Staff #4 moved the shower bed into the hall and CNA #2 moved the Hoyer lift into the hall. Staff #3 removed trash from a trash can, discarded it, and placed the shower bed into the shower room. Staff #4 obtained clean linens and went into room [ROOM NUMBER] to change the sheets on the bed. Staff #4 left room [ROOM NUMBER] and entered Resident W's room. Staff #4 assisted Resident W to turn onto his back. No hand hygiene was performed. 4. On 10/13/15 at 10:06 a.m., CNA #1 and CNA #2 were observed to provide incontinence care for Resident I. CNA #1 and CNA #2 performed hand hygiene and donned gloves. CNA #2 removed Resident I's brief and provided perineal care. CNA #1 and CNA #2 turned Resident I and CNA #2 removed the soiled brief from Resident I's buttocks. CNA #2 cleansed Resident I's buttocks. CNA #2 obtained clean sheets and a clean brief and positioned them under Resident I. CNA #2 adjusted Resident I's brief. CNA #1 and CNA #2 changed Resident I's gown. CNA #1 and CNA #2 repositioned Resident I. CNA #2 removed her gloves and performed hand hygiene for 13 seconds. 5. On 10/14/15 at 9:08 a.m., CNA #1 and CNA #2 were observed to provide a bed bath for Resident J. CNA #2 was observed to cleanse Resident J's buttocks where feces was present. CNA #2 placed a clean brief under Resident J. CNA #2 assisted the resident to roll to the other side. CNA #1 and CNA #2 continued to cleanse Resident J's legs and feet. CNA #2 was not observed to change gloves or perform hand hygiene. CNA #1 and CNA #2 continued to dress Resident J. CNA #1 and CNA #2 removed their gloves and performed hand hygiene. On 10/14/15 at 10:51a.m., CNA #2 was interviewed. CNA #2 indicated gloves are changed and hand hygiene was performed after a residents bath prior to assisting residents with their clean clothes. 6. On 10/08/2015 at 9:44 a.m., Staff #3 did a dressing change on Resident K. Staff #3 walked into the residents room and put on a clean pair of gloves. He proceeded to take off the dirty dressing, clean the wound, applied a clean dressing, all while wearing the same pair of gloves. He then took off the dirty pair of gloves and walked out of the room to the nurses station without washing his hands. On 10/14/15 at 3:11 p.m., the DON presented a Policy for Dressing Change Clean Procedure, last updated on 3/9/15, which included, but not limited to: 1. Place plastic bag near foot of bed to receive soiled dressing 2. Create clean field with paper towels 3. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound 4. Open dressing pack 5. Put on first pair of disposable gloves 6. Remove soiled dressing and discard in plastic bag 7. Dispose of gloves in plastic bag 8. Wash hands 9. Put on second pair of disposable gloves 10. Pour prescribed solution onto gauze to be used for cleaning, if required. 11. Cleanse wound with prescribed solution 12. Apply prescribed medication as ordered 13. Apply dressings and secure with tape 14. Remove gloves and discard with all unused supplies in plastic bag 15. Assist resident to comfortable position with call light in reach. On 10/19/15 at 7:45 a.m., the Administrator provided the Handwashing/Hand Hygiene policy, dated August 2014. The policy included, but was not limited to: vigorously lather hands with soap and rub them together, creating friction to all surfaces, of a minimum of 20 seconds This Federal tag relates to Complaint IN 592 and IN 502. 3.1-18(b)(1) 3.1-18(l)
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 20 of 30 rooms observed. Bathrooms were dirty, resident care equipment was unlabeled, paint was chipped, door thresholds were missing, screws were exposed on the toilet and sink. (Resident S, Room #210, 212, 101, 102, 105, 106, 109, 111, 113, 212, 408, 412, 502, 510, 509, 513, 507, 514, 505). Findings include:

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F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) 1. During an observation on 10/6/15 at 9:30 a.m., Resident S's room was observed to have no mirror above the sink, and a missing top on the sink [MEDICATION NAME]. The same was observed on 10/14/15 at 9:44 a.m. During an interview on 10/6/15 at 9:40 a.m., Resident S indicated her bathroom mirror had fallen and broken two years ago, and that she had requested a new one from the facility. 2. During an observation on 10/5/15 at 10:20 a.m., Room 210 was observed to have chipped drywall and paint on the wall by the bathroom. The same was observed on 10/14/15 at 9:48 a.m. 3. During an observation on 10/5/15 at 10:45 a.m., Room 212 was observed to have peeling paint and drywall behind the bed. The same was observed on 10/14/15 at 9:49 a.m. 4. During an observation on 10/6/15 at 9:38 a.m., Room 101 was observed to have dirt and debris along the edges and in the corners of the cove base, the wall was chipped and marred with black streaks next to the entryway, the caulking at the base of the commode was cracked and stained brown, the grout in the bathroom had dirt and debris in it, screws on the base of the commode were uncapped, and the outside windows had cobwebs on them. The same was observed on 10/13/15 at 9:40 a.m. The bathroom was shared with Room 103. 5. During an observation on 10/5/15 at 11:01 a.m., Room 102 was observed to have dirt/debris along the edges and in the corners of the cove base, dirt and black marks on the floor, a small red round object was in the bathroom on the sink (the resident in Room 102A indicated it was an old radish), a green toothbrush on was on the bathroom sink unlabeled, a coffee cup was on the sink, and the air conditioner/heater grates were bent. The same was observed on 10/13/15 at 9:37 a.m., as well as the green, unlabeled toothbrush was in a potted plant on the sink, screws were uncapped on the base of the commode, and an unlabeled plastic cup, and an unlabeled Styrofoam cup were on the bathroom sink. The room was a shared room. 6. During an observation on 10/5/15 at 2:13 p.m., Room 105 was observed to have a television cable wire hanging from a wall over the chest of drawers of bed A. The same was observed on 10/23/15 at 9:35 a.m. 7. During an observation on 10/6/15 at 9:06 a.m., Room 106 was observed to have dirt/debris along the edges and in the corners of the cove base, the bathroom mirror had dried splatters on it, the bathroom wall above the light switch had holes in it, screws were uncapped at the base of the commode, a long metal bar with a screw in it was propped up against a chest, the floor had black marks on it, and there were holes in the bedroom wall. The same was observed on 10/13/15 at 9:33 a.m. 8. During an observation on 10/6/15 at 9:18 a.m., Room 109 was observed to have dirt/debris along the edges and in the corners of the cove base, the bathroom mirror had dried splatters on it, the screws at the base of the commode were uncapped, and the caulking around the base of the commode was stained brown and cracked. The same was observed on 10/23/15 at 9:34 a.m. except the bathroom mirror was clean. 9. During an observation on 10/6/15 at 9:00 a.m., Room 111 was observed to have dirt/debris along the edges and in the corners of the cove base and the caulking at the base of the commode was cracked and stained brown. The same was observed on 10/13/15 at 9:31 a.m. 10. During an observation on 10/6/15 at 9:28 a.m., Room 113 was observed to have an unlabeled Styrofoam cup on the bathroom sink, an unlabeled black comb on the bathroom sink, a blue denture brush was unlabeled on the bathroom sink, an open tube of toothpaste was on the bathroom sink, the commode had odorous, stagnant urine in it, soiled linens and a pillow were on a trash can in the bedroom, a piece of the entryway ledge was broke off, and paint was chipped off the wall by the closet of bed A. The same was observed on 10/13/15 at 9:28 a.m. except the soiled linens and pillows were gone and the black comb was gone. During observation of the residents room during Stage 1 of the survey the following rooms were observed to have: 11. Room 212 had window blinds which would not open and shut and could not be raised or lowered at 10/5/15 at 11:15 a.m. Observation of room on 10/15/15 at 10:00 a.m. indicated the blinds are unchanged. 12. Room 408 had old urine which had an odor in the bedpan stacked in bathroom on 10/5/15 at 11:36 a.m. 13. Room 412 had floors in bathroom and resident room which were dirty with debris and dirt, bugs (2 gnats) in room flying around room and landing on resident, toilet continuously running, stains of old blood on bedspread, would like paper towel dispenser to be lowered since he is in a wheelchair and it was too high for him to reach. Reobservation of room 10/15/15 at 10:00 a.m. indicated floors in bathroom and resident room still dirty, no bugs observed, stain remains on bedspread, and toilet still running. 14. Room 502 had a sink that drained slowly, yellow ring around sink, and the water drips continuously on 10/5 at 11:50 a.m. Reobservation of room on 10/15/15 at 10:05 a.m. indicated the same to be true 15. Room 510 had blinds which would not open and close, or go up and down, call light is very dim and not audible in or out of room, this room was at end of hall and its view from the nurses desk was obstructed by a sconce in the hallway. Reobservation of room on 10/15/15 indicated at 10:06 a.m., indicated the same to be true. 16. On 10/6/15 at 8:45 a.m., Room #509 was observed. The door threshold from the hallway to the bedroom was observed to be chipped. The drywall in the bedroom was observed to be chipped. In the bathroom, only pieces of the non-slip strips were left. On 10/15/15 at 9:32 a.m., the same was observed. 17. On 10/6/15 at 8:50 a.m., Room #513 was observed. Dirt and debris was observed to be built up on the door thresholds. On 10/15/15 at 9:33 a.m., the same was observed. 18. On 10/5/15 at 11:04 a.m., Room #507 was observed. The caulking around the bathroom sink was observed to be loose. On 10/14/15 at 1:59 p.m., the same was observed. 19. On 10/6/15 at 9:21 a.m., Room #514 was observed. In the bedroom, the floor was observed to be missing pieces. ON 10/15/15 at 9:33 a.m., the same was observed. 20. On 10/6/15 at 1:58 p.m., Room #505 was observed. The door threshold from the hallway to the bedroom was missing. On 10/14/15 at 1:58 p.m., the same was observed. On 10/15/15/ at 10:00 a.m., an interview with Head of Maintenance indicated the blinds are an ongoing problem, he was unaware of the sinks dripping and draining slowly, and toilets which were continuously running. He would check on the paper towel dispenser and the dim call light at the end of hall. He indicated the sun shines on it which makes it look dim. He further indicated he was unaware of the sound being barely audible. He stated they have new call lights to install. On 10/15/15 at 2:00 p.m., the Maintenance Assistant was interviewed. The Maintenance Assistant indicated they check rooms periodically for repairs. He indicated if another staff member observed something in disrepair they fill out a work order for the maintenance staff. On 10/19/15 at 7:45 a.m., the Administrator provided a policy of the cleaning schedule for the facility. This Federal tag relates to Complaint IN 502. 3.1-19(f)
F 0496 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Receive registry verification that a nurse aide has met the required training and skills that the State requires; and 2) ensure nurse aides receive the required retraining after 24 months if nursing related services were not provided for monetary compensation** Based on record review and interview, the facility failed to ensure skill competencies were completed upon orientation for 3 of 28 CNAs reviewed. (CNA #6, CNA #7, CNA #8) Findings include: During record review on 10/15/15 at 1:25 p.m., the personal employee files were reviewed. 1. CNA #5 had a hire date of 6/12/13. CNA #6 lacked documentation of an orientation or skills competency being completed upon hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	**10/19/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRENTWOOD	**30 E CHANDLER AVE EVANSVILLE, IN 47713**

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 0496 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) 2. CNA #6 had a hire date of 4/29/14. CNA #7 lacked documentation of an orientation or skills competency being completed upon hire. 3. CNA #7 had a hire date of 10/15/14. CNA #8 lacked documentation of an orientation or skills competency being completed upon hire. During an interview on 10/15/15 at 1:57 a.m., the Payroll person indicated the facility did not have an orientation or skills competency checklist for the above listed personal. 3.1-14(e)(1)
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** Based on record review and interview, the facility failed to ensure the personal inventory record for residents were not completed for 8 of 26 records reviewed for personal belongings. (Resident L, Resident M, Resident N, Resident O, Resident P, Resident Q, Resident R, Resident K) Findings include: 1. The clinical record for Resident L was reviewed on 10/6/15 at 1:52 p.m. Resident L did not have a personal inventory form in the chart. 2. The clinical record for Resident M was reviewed on 10/6/15 at 1:54 p.m. Resident M had a personal inventory form filled out but it was not signed by the resident and/or responsible party, witnessed by staff, or dated. 3. The clinical record for Resident N was reviewed on 10/6/15 at 1:55. Resident N had a personal inventory form filled out and signed by the responsible party but the form was not witnessed by the staff. 4. The clinical record for Resident O was reviewed on 10/6/15 at 1:58 p.m. Resident O had a personal inventory form on the chart that was filled out but not signed by the resident/responsible party or staff and was not dated. 5. The clinical record for Resident P was reviewed on 10/6/15 at 2:00 p.m. Resident P had a personal inventory form on the chart that was not filled out, signed by the resident/responsible party or staff and was not dated. 6. The clinical record for Resident K was reviewed on 10/15/15 at 2:00 p.m. The personal inventory form was not filled out, signed by the by the resident/responsible party or staff and was not dated. 7. The clinical record for Resident Q was reviewed on 10/15/15 at 2:05 p.m. The personal inventory form was not signed by the resident and/or responsible party, witnessed by staff, or dated. 8. The clinical record for Resident R was reviewed on 10/15/15 at 2:13 p.m. The clinical record did not contain a personal inventory form. During an interview with Staff #4 on 10/15/15 at 2:20 p.m., indicated she had been out to sign a personal inventory form after the resident had been admitted for several days but it had only happened once. Staff #4 further indicated the staff and resident/responsible party fills out the form together on admission and it should be signed and dated at that time by both parties. A policy for resident valuables, obtained from the Medical Records person on 10/19/15 at 4:25 p.m., indicated valuables should be maintained on a separate log and documented with the resident's name, date item received, complete description of the item received or disbursed, value of the item, if known, and name and signature of the person receiving or disbursing the item. This Federal tag relates to Complaint IN 566. 3.1- 50(a)