STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155856	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Goshen, The	1480 Sandpiper LN Goshen, IN 46526

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31719 Based on record review and interview, the facility failed to ensure a resident's family member/Power of Attorney (POA) was notified when a medication was discontinued for 1 of 3 resident's reviewed for medication changes. (Resident B) Finding includes: On 8/7/24 at 3:39 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's disease and depression. A current Care Plan indicated Resident B was at risk for adverse reactions and side effects related to receiving Zoloft for depression. The Care Plan was revised, on 7/17/24, and indicated the POA preferred no GDR (Gradual Dose Reduction) attempts be made. The interventions included, but were not limited to: . Administer antidepressant medications per orders . A Physician Order, dated 10/24/23, indicated Zoloft (Sertraline) 25 milligrams (mg) was started on 10/25/23 for depression. A Consultation Report, from the pharmacy, dated 3/1/24- 5/16/24, indicated the resident was taking Sertraline 25 mg for depression, which was due for a GDR evaluation. The report indicated the resident would benefit from a reduction of Sertraline. The form was signed by the Medical Director, but was undated. The form indicated the physician had accepted the recommendation, but the form did not indicate to discontinue the medication. The Medication Administration Record (MAR) for July 2024 indicated the Zoloft was discontinued on 7/23/24. A Nurse Practitioner Note, dated 7/29/24 at 5:31 P.M., indicated .Review of chart reveals that Sertraline 25 mg was discontinued on 7/23/24. Pt [patient] previously failed GDR of sertraline and episodes of aggravation well managed on low dose of Sertraline. Despite review of chart, unable to determine who discontinued Sertraline and why .restart Sertraline 25 mg, once daily The MAR indicated the Zoloft (Sertraline) was restarted on 7/30/24. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A form titled Guest Satisfaction Concern/Suggestion, dated 7/31/24, was provided by the Administrator, on 8/9/24 at 9:50 A.M. The concern form had been filled out by a family member for Resident B regarding the discontinuation of Zoloft, without notification of the POA (Power of Attorney)/family for Resident B. The form indicated the pharmacy had requested to discontinue the Zoloft and the Medical Director had signed the request and discontinued the medication without consulting the Social Service Director and the prescribing physician. During an interview, on 8/9/24 at 11:35 A.M., the Administrator indicated he could not find the facility's notification to Resident B's family and/or POA regarding the medication change for the Zoloft. On 8/9/24 at 12:50 P.M., the Director of Nursing provided a policy titled, Notification of Change, dated 12/19/22 with revision on 2/14/24, and indicated the policy was the one currently used by the facility. The policy indicated .The facility must inform the resident; consult with the resident's practitioner; and notify, consistent with his or her authority, the resident representative(s) when there is a change in status . Information A change in status would include the following: An accident involving the resident .A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .Procedure .3. The licensed nurse will document in the resident electronic medical record the notification and the information that was provided, including any additional orders from the practitioner This citation relates to Complaint IN00440031. 3.1-5(a)(3)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 31719 Based on observation, interview and record review, the facility failed to ensure a care plan regarding self care deficits and fall risk was implemented for 1 of 3 residents reviewed for staff assisted transfers. (Resident D) Finding includes: On 8/7/24 at 1:34 P.M., Resident D was observed being pushed in her wheelchair to her room, by her husband (Resident B). Resident D's husband was observed positioning the resident's wheelchair beside her bed, then positioned himself in front of Resident D in preparation to transfer her to the bed by himself. CNA 2 entered the room and informed Resident D's husband that she would transfer Resident D to her bed. CNA 2 was then observed to transfer Resident D to the bed, by herself, and reposition her for comfort. Resident B was alert to self only. On 08/7/24 at 2:05 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: Parkinson's Disease, dementia and difficulty walking. A Quarterly MDS (Minimum Data Set) assessment, dated 3/6/24, indicated the resident required substantial/maximal assistance for bed to chair transfers. A Care Plan, dated 8/24/19 and revised on 6/14/24, indicated the resident had a self-care deficit related to Parkinson's Disease and impaired cognitive function. The interventions included, but were not limited to: . Transfer: Guest requires extensive assist of 2 staff for transfers A Care Plan, dated 7/27/21 and revised on 7/17/24, indicated the resident was at risk for a fall related to muscle weakness, dementia and osteoarthritis. The interventions included, but were not limited to: .2 person assist for transfers During an interview, on 8/7/24 at 2:57 P.M., CNA 2 indicated Resident B was a 1 to 2 person assist for transfers, depending on her cooperation during care. CNA 2 had no idea why the Care Plan would say the resident was a 2 person transfer because she did not always need 2 persons to transfer Resident B and sometimes the Resident's husband would transfer her by himself, despite numerous signs in the room reminding him to call staff for assistance. On 8/9/24 at 1:48 P.M., the Director of Nursing provided policy titled, Care Planning, dated 6/24/21, and indicated the policy was the one currently used by the facility. The policy indicated .Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes immeasurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments This citation relates to Complaint IN00439575. 3.1-35(g)(2)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 31719 Based on observation and record review, the facility failed to ensure staff members were present when 3 residents were observed at the dining room table, eating and drinking who required supervision with meals. (Resident M, Resident J and Resident K) Findings include: During an observation, on 8/8/24 at 9:21 A.M., on the Penny Lane unit, CNA 3 exited the building. Resident J, Resident K and Resident M were observed at a long dining room table. All three residents were eating their breakfast and Resident K and Resident M had spouted/lidded cups. Each resident was observed eating and drinking without any assistance or supervision. There were no staff members located in the area of the dining table or in the hallway in view of the dining table. At 9:34 A.M., CNA 3 re-entered the building and went directly to a resident's room and all three residents continued to be unsupervised as they ate. At 9:30 A.M., CNA 3 entered the dining room. She indicated she was unaware the residents were left unsupervised and thought other staff members were in the dining room, as she was taking care of an emergency in another building. 1. On 8/9/24 at 2:50 P.M., P.M., a review of the clinical record for Resident M was conducted. The resident's diagnoses included, but were not limited to: dementia and Parkinson's Disease A Care Plan, dated 1/23/24, with revision on 8/2/24, indicated the resident was a nutritional risk related to his diagnoses of Parkinson's and dementia. The interventions included but were not limited to: .Provide resident with assistance with eating and drinking. A Quarterly Minimum Data Set (MDS) assessment, dated 4/22/24, indicated Resident M required supervision with eating and a helper who provided verbal cues or touching/steadying assistance. 2. On 8/9/24 at 2:58 P.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to: dementia and dysphagia (difficulty swallowing). A current Care Plan, initiated on 12/8/23, indicated the resident was nutritionally at risk related to diagnoses of dysphagia, poor dentition and mechanically altered texture for ease of chewing/swallowing. The interventions included, but were not limited to: provide assistance with eating or drinking, as needed and provide diet of ground meat texture with thin liquids. A Quarterly MDS assessment, dated 3/8/24, indicated the resident required supervision with eating and a helper who provided verbal cues or touching/steadying assistance. 3. On 8/9/24 at 3:06 P.M., a review of the clinical record for Resident K was conducted. The resident's diagnoses included, but were not limited to: dementia and severe protein-calorie malnutrition. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Care Plan, dated 3/21/23 with a revision on 8/7/24, indicated the resident was nutritionally at risk related to diagnosis of dementia and malnutrition with decreased intakes. The intervention included, but were not limited to: provide adaptive equipment-sippy cup, diet mechanical soft with no thin liquids and provide resident with assistance with eating and drinking. A Quarterly MDS assessment, dated 5/6/24, indicated the resident required supervision with eating and a helper who provided verbal cues or touching/steadying assistance. On 8/8/24 at 10:31 A.M., the Administrator provided a policy titled, Meal Service, dated 11/19/21, and indicated the policy was the one currently used by the facility. The policy indicated .6. At least one Nursing staff member will be stationed in the Dining Room during meal service to assist guests/residents with eating, to handle any emergency that might arise, and to monitor guest/resident meal acceptance 1.3-20(h)