

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the investigation of complaint #IN00107119 and complaint #IN00106235.</p> <p>Complaint #IN00106235: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W 227 and W331.</p> <p>Complaint #IN00107119: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W331.</p> <p>Survey dates: April 23, 24, 25, and 26, 2012.</p> <p>Facility Number: 000622 Provider Number: 15G079 AIM Number: 100272170</p> <p>Surveyor: Brenda Nunan, RN Public Health Nurse Surveyor</p> <p>These deficiencies reflect state findings cited in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 4/27/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review, the facility failed to address client's identified program and behavioral needs for 1 additional client to prevent client from giving food to a client with modified food textures and fluid consistencies (client C).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 04/23/2012 at 4:18 p.m. Diagnoses included, but were not limited to history of pneumonia, esophageal reflux disorder and dysphagia (difficulty swallowing).</p> <p>A progress note, dated 02/16/2012 at 2:00 p.m., indicated, " ...staff reported that a peer gave this client a twinkie and pop ... (respirations) unlabored with intermittent cough, O2 (oxygen) @ (at) 89% @ RA (at room air)...Nursing will monitor QS (every shift) x (times) 72 hours and report change of condition to MD (Medical Doctor)...."</p> <p>A progress note, dated 2/25/2012, at 10:47 p.m., indicated, " ...Noted with bil (bilateral) congestion, decreased appetite,</p>	W0227	<p>W227</p> <p>I Corrective Action for Cited Clients: Client C's plan has been reviewed by the IDT and a plan put in place to address him trying to give food to a fellow resident whose diet may be inconsistent with the item.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Residents have been assessed by the team to determine who may try to give food or fluids to their peers whose diet may be inconsistent with items offered. Those who require it have a plan to address this issue. QMRPs, and Client Advocate Department have been trained that one BIR (behavior incident report) regarding sharing of food, will prompt formal action in the ISP and/or BSP for one or</p>	05/26/2012			

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	<p>wheezing and lethargic ...Both lungs with congestion, crackles, coughing up thick greenish mucous ...Pt (patient) was transferred to [hospital] ER (emergency room) for evaluation, a message left for POA (Power of Attorney) "</p> <p>A Progress Note, dated 02/28/2012 at 11:33 a.m., indicated, "...Received client's bedside chest xray (sic) results...Patchy perihilar (where the bronchus begins) and bibasilar (bases of both lungs) pneumonia...."</p> <p>A " Notification of Individual ' s Death, " not dated, indicated terminal diagnosis was Down Syndrome. The record indicated terminal illness diagnosed was moderate oral/severe pharyngeal dysphagia. The record indicated, " ...family declined G-tube feedings ... " The record indicated, " ...Per video swallow study resident aspirated liquid of all consistencies ...Current diagnosis: Right perihilar (refers to foreign substance above and behind heart) area of lungs and left basilar pneumonia, likely of aspiration origin ...Server dysphagia "</p> <p>Client C's Individualized Support Plan (ISP) and Behavior Support Plan (BSP) were reviewed on 04/25/2012 at 10:09 a.m. The ISP and BSP did not indicate client C received training in regard to not</p>		<p>both of the residents involved as is appropriate. (IDT will determine if one or both residents require formal action).</p> <p>IV Monitoring Corrective Measures: Program Directors review plans to assure that giving food to a peer (whose diet may be inconsistent with items offered) is addressed in a formal manner. To be completed by 5-26-12</p>		

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	<p>sharing his food with other clients.</p> <p>During an interview on 04/25/2012 at 9:30 a.m., Program Director (PD) #1 indicated client A received a mechanical soft diet with honey thick liquids due to dysphagia (difficulty swallowing). She indicated client A required staff supervision while eating in the dining room to prevent him from eating regular texture foods from other clients' plates. The PD indicated snacks and drinks provided by the facility were stored at the nurse's station. She indicated client C kept a supply of personal snacks and drinks in his room located in the same hall where client A resided. The PD indicated there was no formal training to ensure client C did not give his food or drinks to other clients. She stated, "[client C's] sister tells him if he gives away food she will not purchase anything for him."</p> <p>During an interview on 04/25/2012 at 9:30 a.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated there were no Interdisciplinary Team (IDT) notes or training programs in place for training client C to avoid sharing his snacks.</p> <p>During an interview on 04/25/2012 at 11:40 a.m., client C stated, "I gave [client</p>				

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	<p>A] chocolate cake once." He stated, "Staff told me not to give food to other clients because of their diets."</p> <p>This federal tag relates to complaint #IN00106235.</p> <p>9-3-4(a)</p>			
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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to ensure nursing services monitored health conditions and failed to revise health risk plans when needed for 2 of 2 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 04/23/2012 at 4:18 p.m. Diagnoses included, but were not limited to history of pneumonia, esophageal reflux disorder and dysphagia (difficulty swallowing).</p> <p>A Progress Note, dated 08/02/2011 at 2:28 p.m. indicated " ...Wheezing noted intermittently bilaterally. Audible without stethoscope "</p> <p>A chest x-ray, dated 08/02/2011, indicated infiltrate in the right lung base. The record did not indicate a follow up x-ray to verify the lungs cleared. The record did not indicate lungs sounds were assessed between 8/04/11 ant 8/10/11.</p> <p>A health risk plan, initiated on 09/30/2011 and revised on 02/03/2012, indicated, "...Mechanically Altered diet</p>			W0331	<p>W331 I Corrective Action for Cited Clients: Training has been completed with the QMRP and Nurse for Residents A and B for completing risk plans which address diet modifications, documentation of assessments completed such as lung sounds, to assemble dining plans for each resident who is deemed "at risk" for choking. Nurse for Resident B trained to complete assessment of residents in a timely manner.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Training completed with QMRPs and Nurse to complete risk plans which address diet modifications, documentation of assessments completed such as lung sounds and to assemble dining plans for each resident who is deemed</p>		05/26/2012

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	<p>provided d/t (due to) hx (history) of chewing difficulty. Fluid restriction d/t over consumption of fluids. The risk plan did not address fluid consistency.</p> <p>A video swallow study, dated 12/05/2011, indicated, "...Moderate swallowing dysfunction "</p> <p>Physician's orders, dated 02/02-02/28/2012, indicated, "...Diets (sic) Regular Texture: Mechanical Soft, Fluid Consistency: Thickened Liquid Honey...."</p> <p>An "Admission Staffing" form, dated 02/02/2012 indicated, "...Diet Mechanical Soft...Liquid Thickened (Nectar)...." The liquid consistency was not consistent with the physician's orders.</p> <p>A health risk plan, initiated 02/09/2012, indicated, "...Alteration in Respiratory Status Due to Respiratory Illness...Patient will have adequate gas exchange as evidenced by no adventitious breath sounds (abnormal respiratory sounds identified through auscultation of the respiratory system with a stethoscope), absence of respiratory distress, and absence of shortness of breath...."</p> <p>A Progress Note, dated 02/09/2012 at</p>		<p>"at risk" for choking. Nurses trained to complete assessment of residents in a timely manner.</p> <p>IV Monitoring Corrective Measures: Program Directors assure that each resident who is "at risk" for choking has a risk plan which addresses diet modifications. DNS/ADNS/Designee reviews SBARS and notes for residents to determine issues and follow up as needed. To be completed by 5-26-12.</p>	

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	<p>9:00 a.m., indicated, "Upon entering client's room, noted cough and chest congestion...Auscultation (listening for sounds within the body {lungs} with a stethoscope) Rhonchi (coarse rattling sound) with congestion in both lungs...." The record did not indicate lungs sounds were auscultated until 02/18/2012 at 10:56 a.m.</p> <p>A progress note, dated 02/16/2012 at 2:00 p.m., indicated, " ...staff reported that a peer gave this client a twinkie and pop ... (respirations) unlabored with intermittent cough, O2 (oxygen) @ (at) 89% @ RA (at room air)...Nursing will monitor QS (every shift) x (times) 72 hours and report change of condition to MD (Medical Doctor)...."</p> <p>A health risk plan, initiated 02/16/2012, indicated, "...Health/Safety risk due to: Pt (patient) non-compliant w/(with) diets food/liquid consistency...Educate patient on food safety and potential risk to health. Educate patient on risks of not following diet restrictions. Provide supervision and redirection meal service and snack times...." The risk plan did not specify the dietary restriction or fluid consistency.</p> <p>A Progress Note, dated 02/19/2012 at 1:59 p.m., indicated, "...client finished with abt (antibiotic) resp (respirations)</p>						

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	<p>even and non labored, chest congestion resolved...." The record did not indicate lung sounds were auscultated or a follow up chest x-ray was completed to verify the lungs were clear.</p> <p>A Speech/Language Pathology (LP) evaluation, dated 2/21/2012, indicated, "...Mechanical Soft diet (symbol for with) thick liquids...."</p> <p>A progress note, dated 2/25/2012, at 10:47 p.m., indicated, "...Noted with bil (bilateral) congestion, decreased appetite, wheezing and lethargic ...Both lungs with congestion, crackles, coughing up thick greenish mucous ...Pt (patient) was transferred to [hospital] ER (emergency room) for evaluation, a message left for POA (Power of Attorney) "</p> <p>A Progress Note, dated 02/28/2012 at 11:33 a.m., indicated, "...Received client's bedside chest xray (sic) results...Patchy perihilar (where the bronchus begins) and bibasilar (bases of both lungs) pneumonia...."</p> <p>A " Notification of Individual 's Death, " not dated, indicated terminal diagnosis was Down Syndrome. The record indicated terminal illness diagnosed was moderate oral/severe pharyngeal dysphagia. The record indicated, "</p>						

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	<p>...family declined G-tube feedings ... "</p> <p>The record indicated, " ...Per video swallow study resident aspirated liquid of all consistencies ...Current diagnosis: Right perihilar (refers to foreign substance in perihilar (above and behind heart) area of lungs and left basilar pneumonia, likely of aspiration origin ...Server dysphagia "</p> <p>During an interview on 04/24/2012 at 12:34 p.m. the Administrator stated, "I would have thought the dining plan would have listed it there" when asked where recommended fluid consistencies should be recorded.</p> <p>During an interview on 04/25/2012 at 10:25 a.m., the Director of Nursing (DoN) and Assistant Director of Nursing (ADoN) indicated staff should have auscultated the lungs when assessing client A's respiratory status.</p> <p>During an interview on 04/25/2012 at 11:30 a.m., CNA (Certified Nursing Assistant) #1 indicated he would get the diet order off the dining plan.</p> <p>During an interview on 04/25/2012 at 11:40 a.m., CNA #2 indicated she would ask the dietitian for diet orders.</p> <p>During an interview on 04/25/2012 at</p>			

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	<p>11:35 a.m. LPN #1 indicated she would assess a client's respiratory status by listening to lung sounds with a stethoscope.</p> <p>During an interview on 04/25/2012 at 11:38 a.m., LPN #2 indicated she would assess a client's respiratory status by listening to lung sounds with a stethoscope.</p> <p>2. Client B's record was reviewed on 04/24/2012 at 10:41 a.m. Nursing Progress Notes, dated 01/14/2012-4/15/2012 did not indicate symptoms of UTI. Client B had dental surgery on 3/15/2012 for multiple teeth extractions. An eye infection was identified on 04/05/012 and treated with ophthalmic antibiotic drops. Client B had a fall documented on 03/21/2012 that resulted in fracture of the left clavicle (shoulder).</p> <p>A Progress Note, dated 04/13/2012 at 11:04 p.m., indicated, "...Resident had crackles (abnormal breath sounds) bilaterally, more confused than usual...5 p.m. vital signs (temperature) 97.3 (degrees Fahrenheit), 76 (pulse), 28 (respiratory rate), O2 sat (amount of oxygen carried to the blood) 90%...6:45 p.m. received orders...send to [hospital]...Left facility at 7:45 p.m. via</p>						

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	<p>stretcher in table condition..."</p> <p>A hospital "History and Physical," dated 04/14/2012 at 2:14 a.m., indicated, "REASON FOR CONSULTATION: UTI (urinary tract infection), lactic acidosis (when lactic acid builds up in blood stream faster than it can be removed, potentially fatal), and septic shock (result of severe infection that has spread via the blood stream)..."</p> <p>A Death Summary, dated 04/16/2012 at 8:47 a.m., indicated, "...She was found to be dehydrated with septic shock and UTI in addition to possible pneumonia based on chest x-ray...Her respiratory status deteriorated and she was placed on the ventilator yesterday....She overall had a poor prognosis given her multiorgan system failure...We called her sister...we talked to her brother...and they all agree about terminal wean (removal of ventilator)...The patient was taken off the ventilator and she shortly died after that..."</p> <p>A "Certificate of Death," filed 04/20/2012, indicated date of death was 04/18/2012 at 3:02 p.m. The certificate indicated the immediate cause of death was urinary tract infection, with sequential conditions leading to the cause of death as sepsis and myocardial</p>						

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	<p>infarction (heart attack).</p> <p>During an interview on 04/25/2012 at 10:51 a.m., RN #1, indicated a CNA reported client B complained of being dizzy. The RN indicated she was passing 4 p.m. medications at the time of the report. She stated, "I 'eye balled' client B to see if there was any acute distress." She stated, "[client B] was confused, but had dementia." The RN indicated she did not check vital signs or complete a nursing assessment until 1 hour later when she finished passing medications. She stated client B had respiratory "crackles" bilaterally (both lungs). She indicated the physician was notified of the change in condition and client B was sent to the hospital for evaluation.</p> <p>During an interview on 04/25/2012 at 11:09 a.m., LPN #3 stated, " [Client B] started screaming 'help, help, help' during the 2nd shift (3 p.m.-11 p.m.). She indicated client B had increased confusion. She stated, "I stepped in the room and heard congestion. I thought she might have pneumonia." The LPN indicated client B complained of "pain all over." The LPN stated client B "required coaxing to go to the hospital." She indicated the client walked to the gurney when the ambulance arrived. She indicated client B was capable of</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
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	<p>reporting pain and discomfort. She indicated client B stated she "hurt all over." The LPN indicated client B was continent of urine and had not reported painful or frequent urination.</p> <p>During an interview on 04/25/2012 at 12:50 p.m., the DoN indicated RN #1 should have checked vital signs and assessed client B at the time the dizziness was reported.</p> <p>This federal tag relates to complaint #IN00106235 and complaint #IN00107119 .</p> <p>9-3-6(a)</p>				