

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 08/15/2014
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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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W000000	<p>This visit was for a post-certification revisit (PCR) survey to the pre-determined full recertification and state licensure survey of 07/01/14.</p> <p>This visit was in conjunction with the PCR survey to the PCR survey of 07/01/14 to the investigation of complaint #IN00147483 completed on 04/25/14.</p> <p>Dates of Survey: August 11, 12, 13 and 15, 2014.</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyors: Vickie Kolb, RN-TC Susan Eakright, QIDP (8/11/14 to 8/13/14) Dotty Walton, QIDP (8/11/14 to 8/13/14) Kathy Wanner, QIDP (8/11/14 to 8/13/14) Glenn David, RN (8/11/14 to 8/13/14) Tim Shebel, QIDP (8/11/14 to 8/12/14) Keith Briner, QIDP (8/12/14 to 8/13/14) Paula Eastmond, QIDP (8/13/14)</p> <p>These federal deficiencies also reflect</p>	W000000		

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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W000104	<p>state findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed 8/27/14 by Ruth Shackelford, QIDP.</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 24 additional clients (clients #16, #17, #20, #21, #22, #23, #24, #25, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, and #44) who lived on the first floor, the facility failed to ensure client closet doors were in place and in good repair.</p> <p>Findings include:</p> <p>During observation on the first floor of the facility on 8/11/14 from 1:20 pm until 2:00 pm, on 8/11/14 from 2:30 pm until 5:25 pm, on 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, clients #1, #2, #3, #4, #16, #17, #20, #21, #22, #23, #24, #25, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, and #44 did not have a closet door and/or a barrier to shield and/or protect their personal belongings</p>	W000104	<p>W104</p> <p>I For residents sited closet doors will be replaced in their bedrooms.</p> <p>II This deficiency may effect all residents who reside at North Willow Center who have missing closet doors.</p> <p>III QMRP staff will review the bedrooms of residents to determine if closet doors are needed replaced or repaired. Building Engine orders will be completed as to needed doors and/or repairs. Maintenance will replace or repair doors as indicated systematically until all work is completed. This work may exceed the date of 9-8-14, however, all doors on 1 north will be done and as many others as possible by that time.</p> <p>IV QMRPs will complete weekly environmental rounds and put needed items of work into building engines. Program Directors will review Building Engine progress twice each month following up as needed.</p>	09/14/2014

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	<p>from view when entering their bedrooms. On 8/13/14 at 8:40 am, clients #3 and #30 both indicated they wanted a closet door in place for their closet inside their bedroom.</p> <p>On 8/13/14 at 8:45 am, an interview with the Director of Nursing (DON) was conducted. The DON indicated the facility's first floor client bedrooms had missing closet doors. The DON indicated she was unsure how long the closet doors were missing and stated the "doors were not" present before 6/2014.</p> <p>On 8/13/14 at 8:45 am, the facility's maintenance work orders were requested for review regarding the first floor missing closet doors. The DON indicated she was unsure if the missing closet doors had been submitted. At 8:45 am, the facility's Administrator indicated she would check on the missing closet doors. No documentation for the first floor missing closet doors was available for review.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-13(a)</p>		Program Directors will complete monthly environmental rounds for their areas of responsibility.				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 8 injuries of unknown origin reviewed, the facility failed to ensure an investigation was conducted for client #114. Findings include: The facility's reportable and investigative records were reviewed on 8/11/14 at 3 PM. The 7/16/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 7/16/14 at 12 PM "[Client #114] not bearing weight to R (right) leg. C/O (Complaining of) knee pain, no swelling, redness, or bruising noted. Received Dr. order to send to [name of hospital] ER (Emergency Room) for evaluation and tx (treatment) of R leg." Client #114's hospital records indicated client #114 had an x-ray of her right knee while at the hospital on 7/16/14 .The X-ray report dated 7/16/14 at 2:29 PM indicated "Full result: Indicated: Trauma</p>	W000154	<p>W154 I For sited resident issue, HRC Director did interview nurse and staff subsequent to the ER visit. These interviews will be documented and additionally the resident will be interviewed and document of that interview as well, all interviews will be added to the packet. II This deficiency may effect all residents who reside at North Willow Center. III Client Advocate and HRC Director will be retrained that any injury of unknown origin must have a compete and thorough investigation. IV Client advocate and HRC Director will review together discharge paperwork form Hospital/ER to assure follow up of all issues and thorough investigation is completed of all issues associated with the visit.</p>	09/14/2014
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	<p>to the right knee with knee pain." The x-ray report indicated "no fracture."</p> <p>The facility Hospital/ER Report of the incident dated 7/16/14 indicated "Hospital Diagnosis: Sprain of Knee." The report indicated "[Client #114] returned to facility 07/16/14 before supper. She (client #114) was placed in wheelchair as a safety measure. Resident abandoned wheelchair as soon as supper appeared in dining room. Gait steady with no c/o pain/discomfort."</p> <p>During interview with the Administrator on 8/11/14 at 12:50 PM, the administrator indicated all injuries of unknown origin were to be investigated.</p> <p>During interview with the HRC (Human Rights Coordinator) on 8/13/14 at 1 PM, the HRC indicated the injury to client #114's leg was not investigated. The HRC indicated all injuries of unknown origin were to be investigated. The HRC indicated client #114 has a history of health issues with her legs and she did not look at the incident as an injury but had overlooked the hospital report of a sprained knee due to trauma. The HRC stated, "I missed it, I guess I should have done an investigation."</p> <p>3.1-28(c)</p>						

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 6 of 13 sampled clients (#1, #4, #6, #7, #8 and #12) and five additional clients (#53, #54, #78, #94 and #114), the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate, integrate and monitor the clients' active treatment programs by failing to ensure:</p> <p>__ Client #12's ISP (Individual Support Plan)/BSP (Behavior Support Plan) indicated how facility staff were to implement client #12's one to one supervision,</p> <p>__ Client #1's dining needs were met in regard to training and to ensure client #1 was provided the correct consistency of liquids.</p> <p>__ Client #4's training objective to wear and care for her eyeglasses was implemented and to ensure client #4's glasses were available to client #4.</p> <p>__ Client #6's, #7's, #8's and #53's positioning schedules indicated what position the client was to be in throughout the day to meet the clients'</p>	W000159	<p>W159</p> <p>I For resident 12 staff have been retrained on her 1-1 supervision and trained that when working 1-1 with a resident the CNA must have relief staff prior to leaving the resident.</p> <p>Resident 1 and 94's dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>Staff have been retrained on resident's 4 objective to wear eye glasses.</p> <p>For sited residents 6, 7, 54 and 78 need for schedule of positioning has been assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>Staff for residents 6, 7, 54 and 78 have been trained to identify and follow up on clothing issues that result in dignity issues.</p>	09/14/2014

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	<p>needs, the supports required for the positioning and to ensure the plan was implemented and documented by the facility staff.</p> <p>__ Clients #6, #7, #54 and #78 were dressed appropriately in public areas of the facility.</p> <p>__ Client #114's injury of unknown origin was thoroughly investigated.</p> <p>__ Client #94's meal time objectives were implemented.</p> <p>Findings include:</p> <p>1. Client #12's BDDS (Bureau of Developmental Disabilities Services) report was reviewed on 8/12/14 at 12:06 PM. Client #12's BDDS report dated 8/8/14 indicated, "[Client #12] was transferred to [hospital] ER (Emergency Room) for evaluation and treatment at 12:05 AM on 8/7/14, returning at 3:40 PM on 8/7/14. [Client #12] was transferred due to striking back of (her) head during maladaptive behaviors at 11:25 PM. [Client #12] presented to nursing at 6:30 AM with discoloration to right hand and forearm as well as left wrist. EMS (Emergency Medical Services) reported to [DON #1 (Director of Nursing)] that [client #12] was observed with supervision of 3 security staff at (the) [hospital] ER prior to her return. [Client #12] was reported to be</p>		<p>For sited resident (114) issue, HRC Director did interview nurse and staff subsequent to the ER visit. These interviews will be documented and additionally the resident will be interviewed and document of that interview as well, all interviews will be added to the packet.</p> <p>II This deficiency may effect all residents who reside at North Willow Center.</p> <p>III One to one supervision will be assigned with approval of the Executive Director and method of supervision will be developed by the IDT.</p> <p>Dining Service Manager assures fluids are available on each floor for meal service.</p> <p>Dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>QMRP staff have assured that adaptive equipment such as eye glasses are on the assignment sheets of the CNA staff. QMRP staff have been trained to check documentation and follow up with potential issues of equipment or need of materials that may prevent implementation of goals and programs. CNA staff also</p>	

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	<p>uncooperative and combative at the ER. [Client #12] was noted with multiple maladaptive behaviors also on 8/4/14, 8/5/14, 8/6/14 and 8/7/14 including throwing self on floor and banging head on floor. [Client #12] was transferred to [hospital] ER at 9:40 AM on 8/6/14 for increased maladaptive and self-injurious behavior resulting in bruising to forehead, eye, buttocks, hip and leg. [Client #12] was returned from both visits with no new orders. [Client #12] is currently on 1:1 (one to one - one staff to one client) supervision and wearing a helmet for protection."</p> <p>Observations were conducted on the third floor of the facility on 8/12/14 from 5:30 AM through 8:30 AM. At 6:20 AM, client #12 was in her bedroom sitting awake in her geri chair. No staff were present in the room. At 6:23 AM, staff #16 came into the room. At 7:50 AM, client #12 was participating in the facility's family style dining with her peers in the dining area. Staff #16 walked around the dining room, assisting other clients, and then returned to stand next to client #12. At 9:00 AM, staff #16 indicated she was going on her 9:00 AM break. Staff #16 stated to staff #17 "I am going on my break now. [Client #12] can stay in the dayroom. She's only on one to one supervision until 9:00 AM." Client</p>		<p>retrained to report any issues with adaptive equipment or need of program items to implement programs and objectives.</p> <p>Residents using wheel chairs have had the need for schedule of positioning assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>Staff have been trained to identify and follow up on clothing issues that result in dignity issues for their residents.</p> <p>Client Advocate and HRC Director will be retrained that any injury of unknown origin must have a compete and thorough investigation.</p> <p>IV Executive Director will review all 1-1 methods of supervision developed by the IDT.</p> <p>Program Directors review Dining Monitor forms and assure that issues related to dining are retrained, disciplined and other appropriate follow up is completed on issues identified.</p> <p>Program Directors are reviewing documentation by the 10th of each month and following up where issues noted indicate need for adaptive equipment or program items.</p> <p>QMRP staff and Nurses observe for positioning schedule being followed and that clothing issues are identified</p>	

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	<p>#12 remained in the unit's dayroom area with staff #17 and 5 peers. At 9:20 AM, staff #16 returned from her break and took client #12 from the dayroom area to client #12's bedroom.</p> <p>Staff #16 was interviewed on 8/12/14 at 6:25 AM. Staff #16 indicated she was assigned to be client #12's one to one ratio supervision.</p> <p>Staff #17 was interviewed on 8/12/14 at 9:00 AM. Staff #17 indicated client #12 was on one to one ratio supervision until 9:00 AM. Staff #17 stated, "When [client #12] is in group she doesn't need a one on one."</p> <p>PM (Program Manager) #1 was interviewed on 8/12/14 at 9:30 AM. PM #1 indicated client #12 should be on one to one ratio supervision at all times. When asked how one to one ratio supervision was to monitor client #12, PM #1 stated, "It's line of sight. They should have her in line of sight at all times."</p> <p>Client #12's record was reviewed on 8/12/14 at 1:25 PM. Client #12's IDT (Interdisciplinary Team) form dated 8/6/14 indicated, "Due to incident of self-injurious behavior, [client #12] will be placed on one to one staffing</p>		<p>and addressed by the staff especially those involving dignity. Nursing rounds are completed each shift and QMRP completes Active Treatment observations as prescribed and makes rounds 5 days each week.</p> <p>Client advocate and HRC Director will review together discharge paperwork form Hospital/ER to assure follow up of all issues and thorough investigation is completed of all issues associated with the visit.</p>				

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	<p>overnight until 9:00 AM tomorrow morning. Staff will be documenting behaviors on the check form and on a BIR (Behavior Incident Report). If staff feel that any of the behaviors could lead to a potential bruising then notify nursing immediately. The IDT plans to implement the following measures for her protection: (1.) [Client #12] will have one to one staffing throughout tonight until tomorrow morning 9:00 AM to evaluate her sleeping patterns and safety needs overnight; (2.) [Client #12] will use a geri chair with tray upon her return from the hospital; (3.) [Client #12] will have a helmet during waking hours to protect her from head trauma; (4.) Floor mats will be placed in her room and used by staff to protect her if she places herself on the floor during behaviors; (5.) [Client #12] will also be provided with pop and other materials (purse, magazines, markers) upon her return."</p> <p>Client #12's ISP dated 7/15/13 and BSP dated 7/15/13 did not indicate how and when facility staff should provide client #12 with one to one supervision. Client #12's record did not indicate documentation regarding a written protocol or plan to specify how client #12's one to one staff should monitor client #12.</p> <p>2. During observation on 8/11/14 from 2:30 pm until 5:25 pm, client #1</p>			
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	<p>consumed her supper meal with facility staff in the dining room walking from table to table. From 4:25 pm until 5:25 pm, client #1 consumed her meal bite after bite of pureed foods without a drink and without prompting to pause between bites of food. After client #1 had consumed her supper meal, facility staff #1 prepared client #1 nectar thick apple juice from a carton of pre thickened liquid labeled "nectar thick, Apple Juice." At 5:15 pm, facility staff #1 stated client #1's liquids were to be "nectar" thickened because client #1 was a choking risk.</p> <p>On 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, client #1 was observed to eat her pureed breakfast bite after bite of food without a drink and without prompting to pause between bites of food. At 9:00 am, client #1 had consumed her food. The surveyor asked if client #1 was to have received a beverage during the meal. Facility staff #2 stated "Oh no, I forgot," facility staff #2 retrieved glasses for the table of clients sitting with client #1, poured client #1 honey thickened milk and honey thickened water from cartons of pre thickened liquid labeled "honey thick, Milk" and "honey thick, Water" on the table. At 9:00 am, facility staff #2 stated client #1's liquids were to have been "honey" thickened because she was a</p>			

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	<p>choking risk.</p> <p>Client #1's record review was conducted on 8/12/14 at 10:15 am. Client #1's 6/3/14-7/21/14 "ST (Speech Therapy) -Therapist Progress & Discharge Summary" indicated client #1 had a diagnosis of "Dysphagia, oropharyngeal phase...Patient responds well to therapeutic cues for liquid every 2-3 bites to clear oral stasis and to take one bite/sip at a time...Due to safety reasons verbal and tactile cues for only taking one bite/sip at a time and utilizing a liquid wash every 2-3 bites to clear oral residue...." Client #1's 6/19/14 ISP (Individual Support Plan) did not indicate a documented dining goal and did not include the Speech Therapist recommendations.</p> <p>On 8/13/14 at 8:45 am, an interview with the Director of Nursing (DON) was conducted. The DON indicated client #1 was at risk to choke and/or aspirate foods/liquids. The DON indicated the facility should follow client #1's Speech Therapist recommendations. The DON stated client #1 should have paused between bites of foods and should have had "honey" thickened liquids. The DON indicated client #1 should have had drinks during the meals not at the end of each meal.</p>			
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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 08/15/2014
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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>On 8/13/14 at 8:00 am, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1 was conducted. QIDP #1 stated client #1 should have had "honey" thickened liquids. QIDP #1 stated "No" client #1 did not have a documented dining goal and should have had a goal to slow her rate of eating, drink honey thickened liquids, and to pause between bites of food. QIDP #1 indicated client #1 should have had drinks during the meals not after client #1 had finished each meal. QIDP #1 stated "No" client #1's ISP had not been revised to include goals for client #1's identified dining needs.</p> <p>3. During observation on 8/11/14 from 1:20 pm until 2:00 pm, on 8/11/14 from 2:30 pm until 5:25 pm, on 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, client #4 sat in her wheelchair, laid in her bed, consumed her meals in the dining room, and sat in her wheelchair inside the activity room. During the four observation periods client #4 was not prompted and/or taught to wear her prescribed eyeglasses by the facility staff.</p> <p>Client #4's record review was conducted on 8/12/14 at 1:50 pm. Client #4's 4/17/14 ISP indicated a written formal</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>goal to wear her prescribed eyeglasses "during waking hours." Client #4's 12/2013 vision evaluation indicated corrective lenses to be worn during waking hours. Client #4's 7/18/14 "Quarterly Review" documented by QIDP #2 indicated "...Learn to tolerate her corrective glasses with Vg (Verbal Guidance)...." Client #4's record did not include reasons why client #4 did not wear her prescribed eye glasses.</p> <p>On 8/13/14 at 8:20 am, an interview with QIDP #2 was conducted. QIDP #2 stated client #4 should have worn her prescribed eyeglasses "during waking hours." QIDP #2 stated he had "no knowledge" of the location of client #4's eyeglasses. QIDP #2 stated client #4 had a written "goal" in place to teach client #4 to wear her prescribed eyeglasses to see. QIDP #2 stated the "ND" documented on client #4's ISP was to signify that "No Data" was collected by the direct care staff for client #4's program to wear her prescribed eyeglasses. QIDP #2 stated he "had not looked into why [client #4's]" goal was recorded as "ND" and/or "if [client #4] had her eyeglasses" available for use.</p> <p>On 8/13/14 at 8:45 am, an interview with the DON was conducted. The DON stated client #4 should have worn her</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>prescribed eye glasses "during awake hours." The DON stated she had "no idea" where client #4's eyeglasses were located currently.</p> <p>4. Observation of client #53 on 8/11/14 at 4:31 P.M. indicated client #53 had a dime sized open area to her upper back at the T1 (First Thoracic Disc) area. The area was not bleeding and was light pink. There was no odor or drainage present. The DON and the ADON (Assistant Director Of Nursing) placed a clean circular padded bandage over the area on client #53's upper back. The DON stated, "Her new wheelchair has helped a lot, but there is a seam at the top of the back cushion and we think she rubbed against it to create the sloughed area. We are using a bandage with extra padding to help prevent further injury while the area heals. We also put a fleece covering over the back cushion of her wheelchair to help protect her skin."</p> <p>Client #53's record was reviewed on 8/12/14 at 3:18 P.M. Client #53's record indicated she had a history of pressure ulcers. A physician's order dated for 8/2014 indicated client #53 was to have "posey pants for hip padding, elbow pads for protection, low air loss mattress with rails per policy and procedures, bed rest with positioning as screened per patient." Client #53's Individual Re-Positioning</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>Plan dated 8/1/2014 indicated "Will be provided with alternate positioning to promote health and skin integrity." Staff Meeting Lecture notes dated 8/1/2014 regarding "[client #53's] skin issue" indicated "Has low air loss mattress, staff will get [client #53] up in her wheelchair for meals and leave her up for a total of 2 hours. Due to [client #53's] recently losing a few pounds, staff will continue to chart the percentage of her meal intake. [Client #53] will be repositioned once each hour. Nursing to perform skin assessment daily until further notice. Ideally this is done at bath time. Hospice will continue to provide service. MD contacted for treatment. Dietary to be informed, Hospice to be informed." Client #53's repositioning data sheet was not filled out for the following dates/times 8/2/2014 7:00 A.M.- 8:00 P.M., 8/6/2014 2:00 P.M.- 8:00 P.M., and 8/7/2014 3:00 P.M.- 8:00 P.M. There was no documentation available for review to indicate repositioning tracking for the overnight hours. Client #53's positioning plan did not indicate how client #53 was to be positioned, and what positions she was placed in to ensure alternate positioning was being completed.</p> <p>Interview was conducted with Program Director/Unit Manager/PD #2 on 8/13/14 at 9:00 AM. PD #2 was asked about the</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>guidelines for repositioning of clients for mobility and positioning to protect skin integrity. PD #2 stated: "Mainly to relieve pressure rather than dictating what position they (clients) are lying in at a particular (time) with the caveat if there is an identified need or certain order, like a doctor's order, to keep someone off of a particular area."</p> <p>Interview with PD #2 on 8/13/14 at 11:28 AM indicated staff were to check clients to see that they were repositioned (exact position right/left side lying, back, bed or wheelchair not specified) every one to two hours according to the nursing and/or doctor's orders. The interview indicated staff were to document the repositioning on the clients' repositioning schedules.</p> <p>5. Client #6's record was reviewed on 8/12/14 at 1:45 PM. Client #6 had an Individual Support Plan/ISP dated 4/24/14. The ISP indicated client #6 received nutrition via Gastric (G) tube. The ISP had an accompanying 4/24/14 Daily Activity (Schedule) which contained training programs/activities for staff to follow/implement. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by staff to indicate in</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>which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair.</p> <p>The positioning schedule was reviewed on 8/13/14 at 11:00 AM. The positioning schedule was not filled out for the morning hours of 8/13/14 6 am to 10 am. The schedule did not specify the location client #6 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 9:00 am to 10:00 am daily. The schedule did not specify how client #6 would be positioned for meals via g-tube or how she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity.</p> <p>Interview with LPN #33 on 8/13/14 at 9:00 am indicated client #6's liquid nutrition received via gastric (G) tube was from 4:00 PM until 9:00 am or 10:00 AM the following mornings.</p> <p>6. Client #7's record was reviewed on 8/12/14 at 2:30 PM. Client #7 had an Individual Support Plan/ISP dated 12/17/13. The ISP had an accompanying 12/17/13 Daily Activity (Schedule) which contained training programs/activities for staff to follow/implement.</p> <p>The schedule did not specify the location client #7 would be (inside or outside 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>her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 4:00 am daily. The schedule did not specify how client #7 would be positioned for meals via g-tube or how she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by staff to indicate in which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair. The positioning schedule was not filled out for the morning hours of 8/13/14 6 am to 10 am.</p> <p>7. Client #8's record was reviewed on 8/12/14 at 3:15 PM. Client #8 had an Individual Support Plan/ISP dated 10/29/13. The ISP had an accompanying 10/29/13 Daily Activity Schedule which contained training programs/activities for staff to follow/implement. The schedule did not specify the location client #8 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her use of a U shaped pillow to assist her with functional positioning during meals when she was fed a pureed diet by staff. The</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>schedule did not specify how client #8 would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by staff to indicate in which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair. The positioning schedule was not filled out for the morning hours of 8/13/14 6 am to 10 am.</p> <p>Interview was conducted with Program Director/Unit Manager/PD #2 on 8/13/14 at 9:00 AM. PD #2 was asked about the guidelines for repositioning of clients for mobility and positioning to protect skin integrity. PD #2 stated: "Mainly to relieve pressure rather than dictating what position they (clients) are lying in at a particular (time) with the caveat if there is an identified need or certain order, like a doctor's order, to keep someone off of a particular area."</p> <p>Interview with PD #2 on 8/13/14 at 11:28 indicated staff were to check clients to see that they were repositioned (exact position right/left side lying, back, bed or wheelchair not specified) every one to two hours according to the nursing and/or</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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W000249	<p>doctor's orders. The interview indicated staff were to document the repositioning on the clients' repositioning schedules.</p> <p>The QIDP/Qualified Intellectual Disabilities Professional failed to ensure 4 of 13 sampled clients, (clients #4, #6, #7 and #8), plus two additional clients (clients #53 and #94), active treatment programs were implemented during formal and informal training opportunities throughout the day. Please see W249.</p> <p>8. The QIDP failed to ensure all injuries of unknown origin were thoroughly investigated for client #114. Please see W154.</p> <p>9. The QIDP failed to promote client dignity and independence by ensuring clients #6, #7, #54 and #78 were dressed appropriately in public areas of the facility. Please see W268.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>2-7-4(a)(2)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</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>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 4 of 13 sampled clients, (clients #4, #6, #7 and #8), plus one additional client (client #94), the facility failed to ensure active treatment programs were implemented during formal and informal training opportunities throughout the day.</p> <p>Findings include:</p> <p>Observations were conducted on the west hall of floor 2 on 8/11/14 from 3:25 pm until 5:45 pm. Clients #6 and #7 were in their shared bedroom. Client #6 was in bed on her back with her legs flexed. Client #7 was in her wheelchair until 4:30 PM when she was positioned into her bed via a Hoyer lift so she could consume her G (gastric)-tube nutritional supplement. Both clients had their television sets on. Clients #6 and #7 were not making eye contact with the televisions. Client #8 went to the dining room for her evening meal at 5:02 pm on 8/11/14. Client #8 was seated in her wheelchair and she did not utilize a U shaped pillow around her neck for functional positioning during the meal.</p>	W000249	<p>W249</p> <p>I Resident 1 and 94's dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>For clients # 4, 6, 7, 8, and for any other clients who are reliant on staff for mobility and do not have a reliable communication method to request to be moved to a specific location, the IDT will meet to further clarify where formal objectives are to be run and specific times to encourage the person to be in a different location, such as out of his/her bedroom.</p> <p>For sited residents 6, 7, 54 and 78 need for schedule of positioning has been assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>II This deficiency may effect all residents who reside at North Willow Center.</p> <p>III</p>	09/14/2014

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 08/15/2014	
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>Nursing staff started feeding client #8 a pureed diet with honey thickened fluids. Program director #2 continued feeding client #8. Client #8 was observed to lean her head backward so the food was offered to her while her mouth was tilted upward.</p> <p>Observations were conducted on the west hall of floor 2 on 8/12/14 from 6:30 am until 10:00 am. Clients #6 and #7 were in their shared bedroom. Client #6 was in bed on her back with her legs flexed. Client #7 was bathed from 6:45 am until 7:20 am when she was returned to her bedroom. Clients #6 and #7 continued to be in their bedroom with television as the only offered activity during the observation period.</p> <p>1. Client #6's record was reviewed on 8/12/14 at 1:45 PM. Client #6 had an Individual Support Plan/ISP dated 4/24/14. The ISP had an accompanying 4/24/14 Daily Activity (Schedule) which contained, in part, the following training programs/activities for staff to follow/implement:</p> <p>"6:30 am-9 am Wake up/Toileting... Answers if wet Y/N (yes/no) Choose appropriate clothing... Choose color shorts/pants</p>		<p>Dining Service Manager assures fluids are available on each floor for meal service.</p> <p>Dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>The QMRP's will audit program books in the classroom to assure that active treatment schedules for each individual are present. The active treatment schedules will reviewed to make sure that it outlines the current active treatment program and is consistent with individual objectives. Review will assure the schedule is flexible, addresses the needs and preferences of the individual, and reflects normal daily rhythms.</p> <p>Residents using wheel chairs have had the need for schedule of positioning assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>IV Program Directors review Dining Monitor forms and assure that issues related to dining are retrained, disciplined and other appropriate follow up is completed on issues identified.</p> <p>QMRP's will include monitoring of the location of active treatment as</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>...Raise head for hair brushing ...Hold toothbrush Med (medication) ... Make eye contact</p> <p>9 am-11 am Domestics...ID (identify) U Pillow, Blanket, Brush Bath...Wash upper part of body Pre-Vocational Attends in classroom....</p> <p>11:30 am-3 pm Lunch Toileting...Answers if wet Y/N G (gastric) tube Program with Recreation</p> <p>3 pm -5 pm Hygiene...Rec (recreational) Activity Toileting/Wash Hands...Answers if wet Y/N Meds G Tube Feeding"</p> <p>The schedule did not specify the location client #6 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 9:00 am to 10:00 am daily. The schedule did not specify how client #6 would be positioned for meals via g-tube or how she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity.</p> <p>Interview with LPN #33 on 8/13/14 at</p>		<p>part of formal and informal active treatment observations.</p> <p>QMRP staff and Nurses observe for positioning schedule being followed and that clothing issues are identified and addressed by the staff especially those involving dignity. Nursing rounds are completed each shift and QMRP completes Active Treatment observations as prescribed and makes rounds 5 days each week.</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>9:00 am indicated client #6's liquid nutrition received via gastric (G) tube was from 4:00 pm until 9:00 am or 10:00 am the following mornings.</p> <p>2. Client #7's record was reviewed on 8/12/14 at 2:30 PM. Client #7 had an Individual Support Plan/ISP dated 12/17/13. The ISP had an accompanying 12/17/13 Daily Activity (Schedule) which contained, in part, the following training programs/activities for staff to follow/implement:</p> <p>"6:30 - 9 am Wake-up & (and) Baths Choose approp (appropriate) clothing dressing goal... Toileting & Hygiene Oral Hygiene... Meds -...</p> <p>9 am - 11 am Pre-Vocational- Recreational Activity Money Goal -... Communication....</p> <p>11:30 am-3 pm G-Tube Program G-Tube feeding Toileting Nap (optional)</p>			

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 08/15/2014	
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>3 pm - 5 pm Hygiene Toileting Socialization (informal) recreational Activities."</p> <p>The schedule did not specify the location client #7 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 4:00 am daily. The schedule did not specify how client #7 would be positioned for meals via g-tube or how she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity.</p> <p>3. Client #8's record was reviewed on 8/12/14 at 3:15 PM. Client #8 had an Individual Support Plan/ISP dated 10/29/13. The ISP had an accompanying 10 /29/13 Daily Activity Schedule which contained, in part, the following training programs/activities for staff to follow/implement:</p> <p>6:30 - 9 am "Wake-up Bathing... Dressing... -Choose appr. (appropriate) clothing -Dressing</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>Oral Hygiene...</p> <p>Breakfast:</p> <ul style="list-style-type: none"> -Hand-washing -Set-up/bf (breakfast) <p>Meds</p> <p>9 am - 11 am</p> <p>Pre-Vocational... recreational Activity Money Goal-... Communication....</p> <p>11:30 am - 3 pm</p> <p>Lunch:</p> <ul style="list-style-type: none"> -Hand-washing -Set-up/lunch - ... <p>Toileting - as needed Nap (optional) Snack</p> <p>3 pm - 5 pm</p> <p>Hygiene Toileting - as needed Socialization (informal) Recreational Activities.</p> <p>5 pm - 8 pm</p> <p>Dinner:</p> <ul style="list-style-type: none"> -Hand-washing -Set-up/dinner - ... <p>Toileting - as needed Oral Hygiene - ... Snack."</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>The schedule did not specify the location client #8 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her use of a U shaped pillow to assist her with functional positioning during meals when she was fed a pureed diet by staff. The schedule did not specify how client #8 would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity.</p> <p>LPN #32 was asked about client #8's U shaped neck pillow and indicated on 8/13/14 at 8:55 AM client #8 was to use the pillow. The pillow was available in client #8's bedroom.</p> <p>Program Director/PD #2 was interviewed on 8/13/14 at 12:11 pm. PD #2 indicated the staff should provide training inside clients' bedrooms and not just in the program rooms or dining room. PD #2 stated staff were trained to prompt and "engage people" (clients).</p> <p>4. During observation on 8/11/14 from 1:20 pm until 2:00 pm, on 8/11/14 from 2:30 pm until 5:25 pm, on 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, client #4 sat in her wheelchair, laid in her bed, consumed her meals in the dining room, and sat in her wheelchair inside the activity room. During the four observation periods</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>client #4 was not prompted and/or taught to wear her prescribed eyeglasses by the facility staff.</p> <p>Client #4's record review was conducted on 8/12/14 at 1:50 pm. Client #4's 4/17/14 ISP indicated a written formal goal to wear her prescribed eyeglasses "during waking hours." Client #4's 12/2013 vision evaluation indicated corrective lens to be worn during waking hours. Client #4's 7/18/14 "Quarterly Review" documented by QIDP #2 indicated "...Learn to tolerate her corrective glasses with Vg (Verbal Guidance)...." Client #4's record did not include reasons why client #4 did not wear her prescribed eye glasses.</p> <p>On 8/13/14 at 8:20 am, an interview with QIDP #2 was conducted. QIDP #2 stated client #4 should have worn her prescribed eyeglasses "during waking hours." QIDP #2 stated he had "no knowledge" of the location of client #4's eyeglasses. QIDP #2 stated client #4 had a written "goal" in place to teach client #4 to wear her prescribed eyeglasses to see. QIDP #2 stated the "ND" documented on client #4's ISP was to signify that "No Data" was collected by the direct care staff for client #4's program to wear her prescribed eyeglasses. QIDP #2 stated he "had not looked into why [client #4's]"</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>goal was recorded as "ND" and/or "if [client #4] had her eyeglasses" available for use.</p> <p>On 8/13/14 at 8:45 am, an interview with the DON was conducted. The DON stated client #4 should have worn her prescribed eye glasses "during awake hours." The DON stated she had "no idea" where client #4's eyeglasses were located currently.</p> <p>5. Observations were conducted in the facility's third floor on 8/12/14 at 7:50 AM through 9:30 AM. At 7:55 AM, client #94 was seated at his assigned table participating in the facility's family style dining. Client #94's table had serving bowls of pureed eggs and oatmeal. No staff were present at client #94's table. Client #94 picked up a serving bowl of pureed oatmeal and utilized the serving spoon to scoop large bites of oatmeal directly from the serving bowl into his mouth.</p> <p>Client #94's record was reviewed on 8/13/14 at 9:15 AM. Client #94's Choking Focus/Goals/Interventions (CFGI) form dated 2/10/14 indicated, "[Client #94] is at risk for choking due to diminished and delayed mastication." Client 94's CFGI form dated 2/10/14 indicated, "Interventions: [Client #94] will have all meals/snacks in the dining</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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W000268	<p>room under close staff supervision. [Client #94's] diet as ordered. Pureed with thin liquids. Educate caregivers regarding safety interventions to prevent choking episodes and regarding the abdominal thrust technique. Follow up with speech therapy if new swallowing difficulties arise. Staff will closely monitor [client #94] during meals and snacks."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #5 was interviewed on 8/13/14 at 10:00 AM. QIDP #5 indicated client #94's meal plan/goals should be implemented. QIDP #5 indicated staff should monitor client #94 during meal times to prevent client #94 from eating food to quickly and to encourage appropriate sized bites of food.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-32(a) 3.1-33(a) 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Observations of an afternoon medication</p>	W000268	W268 I Staff for residents 6, 7, 54 and 78	09/14/2014			

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 08/15/2014	
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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W000331	<p>administration were conducted on 8/11/14 from 4:00 PM until 4:30 PM with LPN #31 (male) in attendance. Client #7's right breast was clearly visible via her right sleeve at 4:20 pm. Client #7 wore no bra or undershirt.</p> <p>On 8/13/14 at 9:00 AM client #78 was in his bedroom unattended. Client #78 walked into the common hallway carrying a pair of pants and a soiled incontinence brief. Client #78 was unclothed from the waist down. Client #78 was putting the soiled brief/pants into waste/laundry containers which were sitting in the hallway outside of his bedroom.</p> <p>Program Director/PD #2 was interviewed on 8/13/14 at 11:45 AM. PD #2 indicated the clients should be wearing appropriate undergarments (underwear) and clothing.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-3(t)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>		<p>have been trained to identify and follow up on clothing issues that result in dignity issues.</p> <p>II This deficiency may effect all residents who reside at North Willow Center.</p> <p>III Staff have been trained to identify and follow up on clothing issues that result in dignity issues for their residents.</p> <p>IV QMRP staff that clothing issues are identified and addressed by the staff especially those involving dignity. QMRP completes Active Treatment observations as prescribed and makes rounds 5 days each week.</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>services in accordance with their needs.</p> <p>Based on observation, record review and interview for 5 of 13 sampled clients (#1, #2, #6, #7 and #8) and 2 additional clients (#27 and #53), the facility nursing services failed to ensure:</p> <p>__ Client #27's plan of care included monitoring of client #27's bowel motility and abdominal distention in regard to a history of bowel obstructions.</p> <p>__ Client #2 was fitted with and provided a wheelchair to meet the client's needs.</p> <p>__ Client #1 was provided honey thickened liquids with her meal.</p> <p>__ Client #6's, #7's, #8's and #53's positioning plans were specific to the clients' needs, indicated the specific position the clients were to be positioned and ensured the staff implemented and documented each clients' positioning per each clients' plan.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 8/11/14 at 3 PM and 8/12/14 at 1 PM.</p> <p>__ The 5/19/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/19/14 at 6:05 PM client #27 had been complaining of nausea and vomiting for two days and was unrelieved with medication and a clear liquid diet. The report indicated</p>	W000331	<p>W331</p> <p>I For resident 12 staff have been retrained on her 1-1 supervision and trained that when working 1-1 with a resident the CNA must have relief staff prior to leaving the resident.</p> <p>Resident 1 and 94's dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>Staff have been retrained on resident's 4 objective to wear eye glasses.</p> <p>For sited residents 6, 7, 54 and 78 need for schedule of positioning has been assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>Staff for residents 6, 7, 54 and 78 have been trained to identify and follow up on clothing issues that result in dignity issues.</p> <p>For sited resident (114) issue, HRC Director did interview nurse and staff subsequent to the ER visit. These interviews will be documented and additionally the resident will be interviewed and document of that interview as well, all interviews will be added to the packet.</p>	09/14/2014

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 08/15/2014
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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>"unable to hold anything down, ab (abdomen) tender when palpated.... hx (history) of intestinal obstruction and constipation." Client #27 was sent to the hospital for evaluation and admitted for treatment.</p> <p>__The 6/2/14 BDDS report indicated on 6/2/14 at 7 AM "[Client #27] had a large coffee ground emesis. Client (#27) alert and responsive.... Lung sounds clear, bs (bowel sounds) x 4 quads (quadrants), non present, abd (abdomen) soft and non distended. Unable to complete percuss (percussion) or palpated d/t (due to) abdomin (sic) surgical incision with sugical (sic) staples...." The report indicated client #27 was sent to the hospital for an evaluation.</p> <p>__The follow up BDDS report dated 6/13/14 indicated "Client returned at 11:50 AM on 6/11/14.... ER (Emergency Room) nurse reported client had large BM (bowel movement) on 6/9/14 plus 2 smalls (small BMS), has had a very good appetite with no emesis... staples out of surgery site.... [Client #27] has been eating his meals without difficulty, no emesis noted, bowel sounds active and vitals within normal limits. Nursing will continue to monitor client per shift as per facility policy and MD order."</p> <p>__The 7/1/14 BDDS report indicated on 7/1/14 at 4 PM "[Client #27] was transferred to [name of hospital] for</p>		<p>Resident 2 now has a tilt n space wheel chair which was rented for his use while we await approval of funding for his chair.</p> <p>For resident 27 abdominal girth measurement will be taken every 24 hours as part of daily abdominal bowel assessment. Volvulus care has been developed for resident 27.</p> <p>II This deficiency may effect all residents who reside at North Willow Center.</p> <p>III One to one supervision will be assigned with approval of the Executive Director and method of supervision will be developed by the IDT.</p> <p>Dining Service Manager assures fluids are available on each floor for meal service.</p> <p>Dining needs are assured by the Dining Monitor which is completed by QMRP, Social Worker, Program Director or Designee. The Dining Monitor assures correct fluids are present on each dining table and that dining objectives are implemented.</p> <p>QMRP staff have assured that adaptive equipment such as eye glasses are on the assignment sheets of the CNA staff. QMRP staff have been trained to check documentation and follow up with potential issues of equipment or need of materials that</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>evaluation and treatment due to nausea and vomiting. Resident has had recent abdominal surgery for bowel obstruction and ileus. Plan to Resolve: Nursing will follow recommendations and any new orders. Nursing will continue to monitor stools as well as complaints and signs of pain and nausea."</p> <p>__The follow up BDDS report dated 7/8/14 indicated "Resident (client #27) recently hospitalized and received surgery for twisted bowel. Resident admitted to [name of hospital] for partial bowel obstruction. Resident returned from hospital 7/5/14 with new orders.... Conclusion: Resident is stable at this time with no further emesis or complaints of nausea. He continues to tolerate a full liquid diet with nectar thickened liquids.... Nursing will continue to monitor for signs of constipation or obstruction."</p> <p>__The BDDS report of 7/29/14 indicated on 7/29/14 at 6:50 AM "Client (#27) noted with large amounts of coffee ground emesis. Sent to [name of hospital] for evaluation."</p> <p>__The follow up BDDS report dated 7/31/14 indicated client #27 was admitted to the hospital.</p> <p>__The follow up BDDS report dated 8/5/14 indicated client #27 was released from the hospital and returned to the facility. "Hx (history): Intestinal</p>		<p>may prevent implementation of goals and programs. CNA staff also retrained to report any issues with adaptive equipment or need of program items to implement programs and objectives.</p> <p>Residents using wheel chairs have had the need for schedule of positioning assessed by Nursing and IDT. If needed, a schedule is in place and trained.</p> <p>Staff have been trained to identify and follow up on clothing issues that result in dignity issues for their residents.</p> <p>Client Advocate and HRC Director will be retrained that any injury of unknown origin must have a compete and thorough investigation.</p> <p>Residents awaiting equipment have been assessed and if appropriate they have had equipment rented while they await approval of Medicaid and or Medicare.</p> <p>Resident diagnosis has been reviewed to identify those residents with diagnosis of Volvulus.</p> <p>IV Executive Director will review all 1-1 methods of supervision developed by the IDT.</p> <p>Program Directors review Dining Monitor forms and assure that issues related to dining are retrained, disciplined and other appropriate</p>	

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 08/15/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>obstruction and constipation. Previously hospitalized on 5/19/14 and 6/2/14 and 7/1/14 (due to DX (diagnoses): Bowel obstruction, Sigmoid Volvulus).... Nursing will continue to monitor client per shift as per facility policy and MD order."</p> <p>Client #27's record was reviewed on 8/12/14 at 3 PM. Client #27's record indicated diagnoses of, but not limited to, Hypertensive encephalopathy (high blood pressure), Dysphagia (difficulty in swallowing), Other functional disorders of the intestines (vital organs in the gastrointestinal tract), Osteoporosis (brittle bones), Unspecified intestinal obstruction, Constipation, Unspecified anemia (lack of red blood cells), Esophageal Reflux, Gastrointestinal Hemorrhage, Cerebral Palsy (disorder of the brain), Diaphragmatic hernia (a defect or hole in the diaphragm that allows the abdominal contents to move into the chest cavity).</p> <p>__Client #27's hospital physician's note of 5/20/14 dictated at 12:05 AM indicated "The patient (client #27) will likely need a neostigmine (a drug used to help relieve severe abdominal distention and fecal impaction) for decompression. If that does not work, may need a colonoscopic decompression.... The</p>		<p>follow up is completed on issues identified.</p> <p>Program Directors are reviewing documentation by the 10th of each month and following up where issues noted indicate need for adaptive equipment or program items.</p> <p>QMRP staff and Nurses observe for positioning schedule being followed and that clothing issues are identified and addressed by the staff especially those involving dignity. Nursing rounds are completed each shift and QMRP completes Active Treatment observations as prescribed and makes rounds 5 days each week.</p> <p>Client advocate and HRC Director will review together discharge paperwork form Hospital/ER to assure follow up of all issues and thorough investigation is completed of</p> <p>Residents with equipment ordered for their use will be discussed by Therapy involved and DNS and ED and other management staff as to the need of renting equipment while awaiting approval from Medicaid and or Medicare.</p> <p>For residents with diagnosis of Volvulus abdominal girth measurement will be taken every 24 hours as part of daily abdominal bowel assessment. Volvulus care has been developed for residents with diagnosis of Volvulus.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient has a long history of colonic distention."</p> <p>__ Client #27's Procedure note dated 5/20/14 indicated client #27 "presented with findings suggestive of sigmoid volvulus (the sigmoid colon twists causing a bowel obstruction). He (client #27) is undergoing colonoscopy for decompression."</p> <p>__ Client #27's hospital discharge summary dated 6/1/14 indicated client #27 presented to the emergency room "for evaluation of 2+ days of difficulty with vomiting and abdominal pain. The patient apparently has had no hematemesis with his vomiting. An x-ray and CT scan do indicate that the patient has significant dilated left sided colon to the extent of 9+ cm (centimeters) around the cecum area as well. The patient has had a long history of chronic problems associated with constipation. The patient is admitted from the extended care facility to [name of hospital] for evaluation of his abdominal distention and bowel obstruction.... Hospital Course: Patient was admitted for evaluation of acute worsening of the chronic hypomotility bowel obstruction syndrome that he has had for years as well as to assess all his other medical concerns. The patient was seen in consultation by General Surgery and they were able to provide attention and care.</p>			

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 08/15/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>He was put on IV fluids and he has had NG (nasogastric) aspiration. It was felt that the patient's problem was one that unfortunately would be continually recurring and that would present as a life threatening concern for him with continued bowel obstruction and perhaps in future infarction of the bowel due to the significant distention. He was taken to the operation room on May 12, 2014 and had a sigmoid colectomy (a surgical procedure to remove part of the colon) performed after having had a colonoscopy performed in which the patient had the volvulus reduced. His hospital course was one of slow return of his colonic hypomotility which required NG placement for aspiration for several days. NG tube was removed about 3 days prior to discharge and he was eating and drinking normally according to the nurses and was having liquid stool....</p> <p>DISPOSITION: He will be discharged today to return to his facility and allowed to take medications."</p> <p>__ Client #27's "Hospital/ER Report" dated 6/2/14 indicated client #27 had a history of "intestinal obstruction and constipation." The report indicated client #27 had diagnoses of, but not limited to, Ileus (a blockage of the intestines caused by a lack of peristalsis - the pumping action of the intestines that helps move food through the digestive system) and</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>Bowel Obstruction.</p> <p>__ Client #27's abdominal x-ray dated 6/2/14 at 12:12 PM indicated "There is persistent distention of the bowel which is overall unchanged compared to the previous study. This may represent ileus or obstruction."</p> <p>__ Client #27's hospital consultation note dictated 6/4/14 at 1:13 PM indicated "[Client #27] was recently admitted for a sigmoid volvulus and underwent a partial colectomy with end to end anastomosis (a surgical joining of the bowel) a couple weeks ago. He was sent back to the nursing home but over there continued to have abdominal pain, nausea and vomiting and was brought back to the hospital. An NG (Nasogastric tube) was placed. Repeat imaging was just with a small bowel x-ray. Mainly the x-rays showed the dilated loops of bowel throughout the abdomen which were pretty much stable like the previous study and a large hiatal hernia (a condition in which part of the stomach sticks upward into the chest through an opening)."</p> <p>__ Client #27's abdominal x-ray of 6/10/14 at 11:41 AM indicated "Abdominal distention.... Gas is seen in multiple bowel loops but overall amount of bowel gas is decreased compared to prior plain film exam."</p> <p>__ Client #27's hospital History and Physical dictated 7/29/14 at 3:24 PM</p>			
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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 08/15/2014	
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>indicated client #27 presented with "reported coffee ground emesis and lower abdominal pain that started today. The patient's last bowel movement was yesterday. Reports that this was non bloody and not dark. The patient felt fine until this morning and previously was tolerating his regular diet without difficulty.... Abdomen: Soft, mildly distended. He is tender in the left lower quadrant and supra pubic regions. There is no guarding or rebound tenderness (pain when touched)...."</p> <p>__ Client #27's hospital discharge summary dated 7/31/14 indicated "The upper endoscopy (exam through a scope) showed a large hiatal hernia and it was felt that his coffee ground emesis was most likely due to esophagitis (an irritation or inflammation of the esophagus). The patient did well and was able to tolerate a clear liquid diet and was advanced to his normal nectar thick diet which he tolerated well without any difficulty. His abdominal pain resolved and he was able to be discharged to his group home in stable condition." Client #27 was discharged with orders for daily laxatives and stool softeners.</p> <p>Client #27's nursing notes indicated, (not all inclusive): __5/18/14 at 13:33 AM "wheeled his (client #27) w/c (wheelchair) to my med</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cart saying his abd. hurt and had a small frothy type emesis small amount, light brown in color..."</p> <p>__5/18/14 at 6:26 PM "continues to complain of nausea and having small emesis..."</p> <p>__5/20/14 at 2:51 PM "Late Entry for 5/19/14; Client (#27) N/V x 2 days... abdomen tender when palpated... to [name of hospital]."</p> <p>__6/1/14 at 2:57 PM "returned to facility via ambulance... 24 staples intact to surgical site..."</p> <p>__6/1/14 at 6:18 PM "Abdomen soft and non distended with bowel sounds active in all quadrants."</p> <p>__6/2/14 at 9:04 AM "Client (#27) experienced large coffee ground emesis... bs (bowel sounds x 4 quads non present, unable to complete full bowel assessment d/t suture stable to abdoment (sic)..."</p> <p>__6/2/14 "May send to [name of hospital] for eval..." Client #27 was admitted for treatment.</p> <p>__6/11/14 at 12:58 PM "Client (#27) returned at 11:50 AM..."</p> <p>__6/11/14 at 10:05 PM "...ab (abdomen) soft and round bowel sounds present x 4 quads."</p> <p>__6/12/14 10:01 PM "No emesis, bowel sounds active..."</p> <p>6/15/14 at 8:51 PM "Client had two episodes of small emesis this evening of undigested food.... Bowel sounds present.</p>			

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 08/15/2014
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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>Stomach round but not distended...." ___6/16/14 at 1:57 PM "... client (#27) did have an extra large loose stool this AM...." 6/17/14 at 10:08 PM "0 emesis this shift, ab soft and round bowel sounds present x 4 quads." ___7/1/14 at 3:08 AM "small emesis at 0550..." 7/1/14 at 12:47 PM "Client (#27) has been in bed all day per his request and has refused both meals...." 7/1/14 at 3 PM "no bm this shift, abd. soft and non-distended with positive bowel sounds...." 7/1/14 at 7:46 PM "Client has had emesis throughout the night and 3x within a half hour this shift. C/O (Complaining of) ab pain.... Ab tender to the touch, ab non distended, faint bowel sounds x 4 quads...." Client #27 was sent to the ER for evaluation and admitted for treatment. ___7/5/14 at 11:10 PM "Client (#17) back from hospital at 10:15 PM...." ___7/6/14 at 10:15 AM "... Bowel sounds present in all quadrants...." ___7/6/14 at 6:17 PM "...ab soft and round bowel sounds present x 4 quads...." ___7/7/14 at 10:28 PM "...ab soft an round bowel sounds present x 4 quads...." ___7/29/14 at 3:03 PM "emesis.... X-large amount of coffee ground emesis noted at 6:50 AM, was called to client's (#27) room by client's roommate where writer</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observed dark brown emesis on the floor and on the bed next to client... writer asked client if his abd. was upset and client replied no denied any c/o to writer. Writer called [name of ambulance service] to have client transported to [name of hospital] for evaluation...." ___7/31/14 at 9:26 PM "Client (#27) returned from hospital at 1730 with no new orders.... BS x4 quads." ___8/1/14 at 10:05 PM "... ab soft and round bowel sounds present x 4 quads." 8/1/14 at 3:24 AM "...abdomen soft non distended, percussion with hollow sound. Client (#27) now wears briefs and is both continent and incontinent at times. Last BM ex large 8/2/14...." ___8/3/14 3:24 PM "abdomen soft non distended, percussion with hollow sound... last BM ex large 8/2/14...." 8/8/14 at 4:02 PM "Client (#27) refused breakfast but ate 100% of lunch, for breakfast did drink fluids and ate pudding with his meds, was reported this AM had a lg (large) loose stool. Client denied feeling ill."</p> <p>Client #27's record did not indicate a measurement of client #27's abdomen in regard to a base line of abdominal girth (the measurement of the distance around the abdomen at a specific point) in regard to the client's history of ileus, distention and bowel obstructions.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	<p>Client #27's Risk Plan for constipation dated 6/1/14 indicated: "Bowel medication as ordered. Monitor use and effectiveness. Monitor and report changes in ability to toilet or continence status. Monitor bowel status frequency. Scheduled toileting plan of (assist to sit on toilet every evening after supper. Place on bedpad every morning after daily suppository administered by nurse. Use of briefs/pads for incontinence protection."</p> <p>__ Client #27's Risk Plan for constipation did not include how nursing was to assess client #27 in regards to bowel sounds, bowel motility, abdominal pain and abdominal distention/abdominal girth (the measurement of the distance around the abdomen at a specific point).</p> <p>The 6/14/12 facility "Bowel Program" was reviewed on 8/13/14 at 11:30 AM. The program was hand written on a physician's order. The Program indicated "If no BM in 3 days, do physical assessment of client - assess for bowel sounds x 4 quadrants - may give MOM (Milk of Magnesia) 30 cc (cubic centimeters) po (by mouth) or G tube QD (every day) PRN (as needed) - Notify physician if poor results or no BM in 6 - 8 hours."</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>During interview with RN #1 on 8/13/14 at 11:15 AM, RN #1 indicated client #27's bowel movements were being monitored daily by the CNAs (Certified Nursing Assistants). RN #1 indicated nursing followed the same facility bowel program for all clients. When asked what was the facility bowel program, RN #1 indicated if the client was to have no bowel movement in three days then the nurse would give the client a laxative. When asked how often was client #27's abdomen assessed for bowel sounds, motility and distention, RN #1 stated, "If he hasn't had a BM for three days then we (nursing) would do an assessment." RN #1 indicated nursing did not do a bowel or abdominal assessment on client #27 on a daily or a regular basis. When asked should client #27 be monitored more closely due to his medical history and frequent hospitalization, RN #1 stated, "That's a good idea. I'll call the doctor and see if he wants us to do that." RN #1 indicated measurement of client #27's abdomen in regard to abdominal girth was not included in client #27's plan of care.</p> <p>Interview with the DON (Director of Nursing) on 8/13/14 at 12 PM indicated nursing followed the facility Bowel Program provided by the facility doctor in regards to assessing all clients for</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>constipation.</p> <p>2. During observation on 8/11/14 from 2:30 pm until 5:25 pm, client #1 consumed her supper meal with facility staff in the dining room walking from table to table. From 4:25 pm until 5:25 pm, client #1 consumed her meal bite after bite of pureed foods without a drink and without prompting to pause between bites of food. After client #1 had consumed her supper meal, facility staff #1 prepared client #1 nectar thick apple juice from a carton of pre thickened liquid labeled "nectar thick, Apple Juice." At 5:15 pm, facility staff #1 stated client #1's liquids were to be "nectar" thickened because client #1 was a choking risk.</p> <p>On 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, client #1 was observed to eat her pureed breakfast bite after bite of food without a drink and without prompting to pause between bites of food. At 9:00 am, client #1 had consumed her food. The surveyor asked if client #1 was to have received a beverage during the meal. Facility staff #2 stated "Oh no, I forgot," facility staff #2 retrieved glasses for the table of clients sitting with client #1, poured client #1 honey thickened milk and honey thickened water from cartons of pre thickened liquid labeled "honey thick,</p>			
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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 08/15/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Milk" and "honey thick, Water" on the table. At 9:00 am, facility staff #2 stated client #1's liquids were to have been "honey" thickened because she was a choking risk.</p> <p>Client #1's record review was conducted on 8/12/14 at 10:15 am. Client #1's 6/3/14-7/21/14 "ST (Speech Therapy) -Therapist Progress & Discharge Summary" indicated client #1 had a diagnosis of "Dysphagia, oropharyngeal phase...Patient responds well to therapeutic cues for liquid every 2-3 bites to clear oral stasis and to take one bite/sip at a time...Due to safety reasons verbal and tactile cues for only taking one bite/sip at a time and utilizing a liquid wash every 2-3 bites to clear oral residue...."</p> <p>On 8/13/14 at 8:45 am, an interview with the Director of Nursing (DON) was conducted. The DON indicated client #1 was at risk to choke and/or aspirate foods/liquids. The DON indicated the facility staff were to follow client #1's Speech Therapist recommendations. The DON stated the staff should have prompted client #1 to pause between bites of foods and ensured client #1's liquids were "honey" thickened liquids. The DON indicated client #1 should have had drinks during the meals not at the end</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>of each meal.</p> <p>3. During observation on 8/11/14 from 1:20 pm until 2:00 pm, on 8/11/14 from 2:30 pm until 5:25 pm, on 8/12/14 from 6:30 am until 9:15 am, and on 8/13/14 at 8:40 am, client #2 sat in his molded wheelchair. Client #2's head did not touch his head rest, client #2 sat in a vinyl seat with multiple splits into the covering, client #2's seat had two four plus inch splits into the seat and exposed gouges with rough edges against client #2's clothing, client #2's right/left feet and legs dangled without support from his seated position in the wheelchair, and his right/left wheels on the wheelchair were worn. Client #2's right/left wheelchair foot rests were broken flat metal base without sides to support client #2's foot positions while seated in the wheelchair. Client #2's seat belt had frayed edges and was tied together, then snapped into place.</p> <p>Client #2's record review was conducted on 8/12/14 at 12:45 pm. Client #2's 6/3/14 ISP (Individual Support Plan) indicated he used an adapted molded wheelchair individualized for client #2's identified need of Cerebral Palsy and "Abnormal Posture." Client #2's 7/15/14 "Occupational Therapy (OT) Plan" indicated "Patient is a 24 year old male</p>			
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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 08/15/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>who presents with positioning deficits as a result of ill fitting w/c (wheelchair) that pt (patient) is currently in...which have resulted in poor overall positioning as well as risk of decline in skin integrity d/t (due to) rips in seating system...uses staff for all mobility...Patient requires a manual wheelchair which is necessary for head, neck, and trunk mobility...to allow for proper positioning to maintain neutral midline alignment and freedom for sue of upper extremities...." The OT plan indicated client #2 will "require angle adjustable foot plates with shoe holders required to hold lower extremities in place on the foot plates. Client has no active movement in his lower legs." The OT plan indicated client #2 "needed" the following adaptations to a new wheelchair: stroller handles, harness, full length arm rests, flip back arm rests, height adjustable arm rests, pneumatic wheels, flat free wheels, back positioning 19", a tilt manual recline, a skin protection adjustable cushion, a push to lock wheel locks, shoe holders with angle adjusters, a swing away hardware headrest, a push button pelvic positioner, and 70 degrees of leg rests.</p> <p>On 8/13/14 at 8:45 am, an interview with the Director of Nursing (DON) was conducted. The DON indicated client #2's wheelchair was on order since</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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7/15/14 and stated "Medicaid approval takes time." The DON stated client #2 was not "correctly" positioned in his wheelchair to "support" client #2's comfort. The DON stated client #2 "needed a new wheelchair." The DON stated client #2's feet "dangled without support" to his feet and legs. The DON stated client #2's head "did not" touch his head rest, the wheels were worn, and client #2's "wheelchair needed replaced." The DON indicated client #2 had needed a new wheelchair before 6/2014.</p> <p>4. Observations were conducted on the west hall of floor 2 on 8/11/14 from 3:25 pm until 5:45 pm.</p> <p>Clients #6 and #7 were in their shared bedroom. Client #6 was in bed on her back with her legs flexed. Client #7 was in her wheelchair until 4:30 PM when she was positioned into her bed via a Hoyer lift so she could consume her G (gastric) -tube nutritional supplement. Both clients had their television sets on. Clients #6 and #7 were not making eye contact with the televisions. Client #8 went to the dining room for her evening meal at 5:02 pm on 8/11/14. Client #8 was seated in her wheelchair and she did not utilize a U shaped pillow around her neck for functional positioning during the meal. Nursing staff started feeding client #8 a pureed diet with honey thickened fluids. Program director #2 continued feeding</p>			

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 08/15/2014
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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>client #8. Client #8 was observed to lean her head backward so the food was offered to her while her mouth was tilted upward.</p> <p>Observations were conducted on the west hall of floor 2 on 8/12/14 from 6:30 am until 10:00 am. Clients #6 and #7 were in their shared bedroom. Client #6 was in bed on her back with her legs flexed. Client #7 was bathed from 6:45 am until 7:20 am when she was returned to her bedroom. Clients #6 and #7 continued to be in their bedroom with television as the only offered activity during the observation period.</p> <p>Client #6's record was reviewed on 8/12/14 at 1:45 PM. Client #6 had an Individual Support Plan/ISP dated 4/24/14. The ISP indicated client #6 received nutrition via Gastric (G) tube. The ISP had an accompanying 4/24/14 Daily Activity (Schedule) which contained training programs/activities for staff to follow/implement. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by staff to indicated in which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair.</p>			

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 08/15/2014
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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>The schedule did not specify the location client #6 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 9:00 am to 10:00 am daily. The schedule did not specify how client #6 would be positioned for meals via g-tube or how she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity.</p> <p>Interview with LPN #33 on 8/13/14 at 9:00 am indicated client #6's liquid nutrition received via gastric (G) tube was fed from 4:00 am until 9:00 am or 10:00 am the following mornings.</p> <p>Client #7's record was reviewed on 8/12/14 at 2:30 PM. Client #7 had an Individual Support Plan/ISP dated 12/17/13. The ISP had an accompanying 12/17/13 Daily Activity (Schedule) which contained training programs/activities for staff to follow/implement.</p> <p>The schedule did not specify the location client #7 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her gastric tube feeding schedule of 4:00 pm until 4:00 am daily. The schedule did not specify how client #7 would be positioned for meals via g-tube or how</p>			
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	<p>she would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by staff to indicate in which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair.</p> <p>Client #8's record was reviewed on 8/12/14 at 3:15 PM. Client #8 had an Individual Support Plan/ISP dated 10/29/13. The ISP had an accompanying 10/29/13 Daily Activity Schedule which contained training programs/activities for staff to follow/implement. The schedule did not specify the location client #8 would be (inside or outside of her bedroom) for programming activities. Absent from the schedule was her use of a U shaped pillow to assist her with functional positioning during meals when she was fed a pureed diet by staff. The schedule did not specify how client #8 would be positioned (wheelchair/bed/supine or side lying) to ensure good skin integrity. The record review indicated a "repositioning chart" broken into 2 hour increments. The chart did not specify how the client was to be positioned. The chart was filled out by</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>staff to indicate in which position the client was in during the 2 hour checks; left/right side lying, on back or in wheelchair.</p> <p>LPN #32 was asked about client #8's U shaped neck pillow and indicated on 8/13/14 at 8:55 am client #8 was to use the pillow. The pillow was available in client #8's bedroom.</p> <p>Interview was conducted with Program Director/Unit Manager/PD #2 on 8/13/14 at 9:00 am. PD #2 was asked about the guidelines for repositioning of clients who relied on staff for mobility and positioning to protect skin integrity. PD #2 stated: "Mainly to relieve pressure rather than dictating what position they (clients) are lying in at a particular (time) with the caveat if there is an identified need or certain order, like a doctor's order, to keep someone off of a particular area."</p> <p>Interview with PD #2 on 8/13/14 at 11:28 am indicated staff were to check clients to see that they were repositioned (exact position right/left side lying, back, bed or wheelchair not specified) every one to two hours according to the nursing and/or doctor's orders. The interview indicated staff were to document the repositioning on the clients' repositioning schedules.</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>5. Observation of client #53 on 8/11/14 at 4:31 P.M. Client #53 had a dime sized open area to her upper back at the T1 (First Thoracic Disc) area. The area was not bleeding and was light pink. There was no odor or drainage present. The DON and the ADON (Assistant Director Of Nursing) placed a clean circular padded bandage over the area on client #53's upper back. The DON stated, "Her new wheelchair has helped a lot, but there is a seam at the top of the back cushion and we think she rubbed against it to create the sloughed area. We are using a bandage with extra padding to help prevent further injury while the area heals. We also put a fleece covering over the back cushion of her wheelchair to help protect her skin."</p> <p>Client #53's record was reviewed on 8/12/14 at 3:18 P.M. Client #53's record indicated she had a history of pressure ulcers. A physician's order dated for 8/2014 indicated client #53 was to have "posey pants for hip padding, elbow pads for protection, low air loss mattress with rails for policy and procedures, bed rest with positioning as screened per patient." Client #53's Individual Re-Positioning Plan dated 8/1/2014 indicated "Will be provided with alternate positioning to promote health and skin integrity." Staff</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>Meeting Lecture notes dated 8/1/2014 regarding "[client #53's] skin issue" indicated "Has low air loss mattress, staff will get [client #53] up in her wheelchair for meals and leave her up for a total of 2 hours. Due to [client #53's] recently losing a few pounds, staff will continue to chart the percentage of her meal intake. [Client #53] will be repositioned once each hour. Nursing to perform skin assessment daily until further notice. Ideally this is done at bath time. Hospice will continue to provide service. MD contacted for treatment. Dietary to be informed, Hospice to be informed." Client #53's repositioning data sheet was not filled out for the following dates/times 8/2/2014 7:00 A.M.- 8:00 P.M., 8/6/2014 2:00 P.M.- 8:00 P.M., and 8/7/2014 3:00 P.M.- 8:00 P.M. There was no documentation available for review to indicate repositioning tracking for the overnight hours. Client #53's positioning plan did not indicate how client #53 was to be positioned, and what positions she was placed in to ensure alternate positioning was being completed.</p> <p>Interview was conducted with Program Director/Unit Manager/PD #2 on 8/13/14 at 9:00 AM. PD #2 was asked about the guidelines for repositioning of clients for mobility and positioning to protect skin integrity. PD #2 stated: "Mainly to relieve</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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W000382	<p>pressure rather than dictating what position they (clients) are lying in at a particular (time) with the caveat if there is an identified need or certain order, like a doctor's order, to keep someone off of a particular area."</p> <p>Interview with PD #2 on 8/13/14 at 11:28 AM indicated staff were to check clients to see that they were repositioned (exact position right/left side lying, back, bed or wheelchair not specified) every one to two hours according to the nursing and/or doctor's orders. The interview indicated staff were to document the repositioning on the clients' repositioning schedules.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-17(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review and interview for 1 of 13 sample clients (#4) and 18 additional clients (clients #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47 and #48), the facility failed to ensure all</p>	W000382	<p>W382</p> <p>I Nurse for sited residents has been retrained to lock the medication cart and keep medications secured.</p> <p>II This deficiency may effect all residents who reside at North Willow</p>	09/14/2014

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 08/15/2014
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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>medications were secured until ready for administration</p> <p>Findings include:</p> <p>An observation was conducted on 8/13/14 from 10:40 AM until 10:45 AM at the facility on the first floor north hallway where clients #4, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47 and #48 resided. During this period, a medication cart was sitting against the wall in the middle of the hallway. The medication cart was not locked and this surveyor opened all three large drawers of the medication cart revealing medications for the clients living on the north hall of the first floor of the facility. Several clients walked nearby the cart and no facility nurse and/or staff were in the hallway monitoring the medication cart. The unlocked medication cart was brought to the attention of the DON (Director of Nurses) who immediately locked the medication cart.</p> <p>Interview with the DON on 8/13/14 at 10:45 AM indicated all medications were to be secured at all times. The DON indicated all medication carts were to be locked except when in use and/or were directly supervised by a facility nurse.</p>		<p>Center.</p> <p>III Nurses have been retrained to lock the medication cart and keep medications secured.</p> <p>IV DNS/Designee audits twice each week for security of medication then monthly thereafter.</p>	
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W000473	<p>Review of the revised June 2005 "Oral Medication Administration Procedure" on 8/13/14 at 11 AM indicated "Medication cart is to be kept locked at all times unless in use and within nurse's sight and control."</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(1)</p> <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation, record review, and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 28 additional clients (clients #14, #15, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #33, #35, #36, #39, #40, #42, #43, #45, #46, #47, and #48) who consumed their breakfast in the first floor dining room, the facility failed to ensure cold beverages were served at or below 45 degrees Fahrenheit and hot food was served at or above 140 degrees Fahrenheit.</p> <p>Findings include:</p>	W000473	<p>W473</p> <p>I Dietary staff have been retrained as to temperature requirements and to serve food only from hot cart.</p> <p>II This deficiency may effect all residents who reside at North Willow Center.</p> <p>III Food and beverage temperatures are taken at each meal.</p> <p>IV Dietary Service Manager takes temperatures weekly and Dietitian takes temperatures during her visits which are scheduled for weekly.</p>	09/14/2014

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 08/15/2014
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	<p>During observation on the first floor dining room on 8/12/14 from 7:40 am until 9:15 am, clients #1, #2, #3, #4, #14, #15, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #33, #35, #36, #39, #40, #42, #43, #45, #46, #47, and #48 consumed their breakfast in the first floor dining room. From 7:40 am until 9:15 am, clients were served their Orange Juice from Orange Juice pitchers on top of a serving cart and the temperature of the Orange Juice was fifty-one (51) degrees Fahrenheit. At 7:40 am, the cook loaded pans of menu items of pureed consistency, mechanical soft consistency, and regular consistency prepared pans into the steam table on the first floor and took the temperatures. At 7:40 am, the first floor cook stated the eggs with bacon for pureed foods was 120 degrees, the mechanical soft was "120" degrees, and the regular was "120" degrees. At 7:40 am, the first floor cook stated the "hot foods should be 140 (degrees Fahrenheit) and the cold foods (and drinks) should be 41 (forty-one degrees Fahrenheit)" or below. From 7:40 am until 9:15 am, clients #1, #2, #3, #4, #14, #15, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #33, #35, #36, #39, #40, #42, #43, #45, #46, #47, and #48 consumed their meal. At 8:50 am, the first floor cook and the Certified Dietary Manager</p>			

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	<p>(CDM) both stated the Orange Juice was "51" degrees, the Oatmeal was "115" degrees, and the eggs with bacon was "125" degrees. At 8:50 am, the facility's "8/12/14 Temperature Log Form" completed by the cook on the first floor dining room serving steam table indicated the following: "...Pureed Meat 140 F (Fahrenheit) or above (was) 120, Mech (Mechanical) Soft Meat 140 F or above (was) 120, Reg (Regular) Meat 140 F or above (was) 120...Pureed Starch 140 F or above (was) 160...." At 8:50 am, the CDM and the first floor cook both stated the temperature of the Orange Juice should have been below "41" according to the facility's policy and procedure and the hot foods should have been "above 140" degrees Fahrenheit.</p> <p>On 8/13/14 at 11:41 am, a record review of the facility's undated "Holding and Serving" food indicated "The Dining Services department will serve refrigerated foods at 41 (degrees) F (Fahrenheit) or below...." The policy and procedure indicated hot foods should be served at 140 degrees Fahrenheit or above.</p> <p>This deficiency was cited on 7/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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