

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  06/29/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the investigation of complaint #IN00109013.</p> <p>This visit was in conjunction with a post-certification revisit (PCR) survey to the investigation of complaints #IN00108475 and #IN00107765 completed on 5/23/12. This visit resulted in an Immediate Jeopardy.</p> <p>This visit was in conjunction with a PCR to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12.</p> <p>This visit was in conjunction with a PCR to the investigation of complaint #IN00103890 completed on 3/26/12.</p> <p>This visit was in conjunction with a PCR to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12.</p> <p>Complaint #IN00109013: Substantiated, Federal and state deficiency related to the allegation(s) is cited at W368.</p> <p>Unrelated Deficiency cited.</p> <p>Dates of Survey: 6/25, 6/26, 6/27, 6/28 and 6/29/12</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Facility Number: 000622 Provider Number: 15G079 Aim Number: 100272170</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Keith Briner, Medical Surveyor III Brenda Nunan RN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 7/10/12 by Ruth Shackelford, Medical Surveyor III.</p>			
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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to ensure all medications were administered as ordered by the physician for 5 of 9 sampled clients (clients #1, #3, #4, #5 and #6).</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 06/27/2012 at 9:45 a.m. Client #4's Medication Administration Record (MAR), dated 03/01/2012-03/31/2012, lacked documentation to indicate Ferrous Sulfate 750 mg was administered at 5:00 p.m. on 03/24/2012 and 03/25/2012. The MAR lacked documentation to indicate Oyster Shell Calcium 500 mg was given at 5:00 p.m. on 03/25/2012 and lacked documentation to indicate Dilantin Infatabs 100 mg was given on 03/25/2012 at 5:00 p.m.</p> <p>The Physician's orders, dated 03/01/2012-03/31/2012, indicated client #4 received "...Ferrous Sulfate (iron supplement) 750 mg (milligrams) Two times a day.....Oyster Shell Calcium (supplement) 500 mg Two times a day...Dilantin Infatabs (seizure</p>	W0368	<p><b><u>W368 Drug Administration</u></b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p><b><u>I Corrective Action for Cited Clients:</u></b> Nursing checks each others MAR record for completion prior to the end of their shift and signs off.</p> <p><b><u>II Other Clients Potentially at Risk:</u></b> All residents of North Willow are potentially at risk for this incorrect practice.</p> <p><b><u>III Corrective Measures or Systemic Changes:</u></b> Program Directors audit MARs weekly with follow up as needed.</p> <p><b><u>IV Monitoring Corrective Measures:</u></b> Audit results reported to DNS/ADNS for further action and progressive discipline may be taken by Program Director or other Management staff when warranted.</p>	07/29/2012	

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	<p>medication) 50 mg Three Times a Day give 2 tabs (tablets) = 100 mg...."</p> <p>Client #4's MAR, dated 04/01/2012-04/30/2012, lacked documentation to indicate Oyster Shell Calcium 500 mg was given at 8:00 a.m. on 04/24/2012 and Bethanachol Chloride 25 mg was given at 12:00 p.m. on 04/29/2012.</p> <p>The Physician's orders, dated 04/01/2012-04/30/2012, indicated client #4 received, "...Oyster Shell Calcium (supplement) 500 mg Two times a day...Bethanachol Chloride (used to treat certain bladder problems) 25 mg (milligram) Three Times a Day...."</p> <p>Client #4's MAR, dated 05/01/2012-05/31/2012, lacked documentation to indicate Folic Acid 1 mg (milligram) was administered at 8:00 a.m. on 05/16/2012 and 05/28/2012. The record lacked documentation to indicate Bethanachol Chloride 25 mg was administered at 12:00 p.m. on 05/23/2012.</p> <p>The Physician's orders, dated, 05/01/2012-05/31/2012, indicated client #4 received "...Folic Acid (to treat certain types of anemia) 1 mg once a day...Bethanachol Chloride 25 mg Three</p>			

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	<p>Times a Day...."</p> <p>2. Client #5's record was reviewed on 06/26/2012 at 1:30 p.m. Client #5's MAR, dated 04/01/2012-04/30/2012, lacked documentation to indicate Calcium Carbonate-Vitamin D 600 mg/400 IU, Keppra 750 mg, and Prevident were administered at 8:00 a.m. on 04/14/2012.</p> <p>The Physician's orders, dated 04/01/2012-04/30/2012, indicated client #5 received "...Calcium Carbonate-Vitamin D (supplement) 600 mg/400 IU, Keppra 750 mg, and Prevident (dental rinse) 0.2% Two times a day SWISH A SMALL AMT (amount) FROM A SMALL CUP AFTER BRUSHING...."</p> <p>Client #5's MAR, dated 05/01/2012-05/31/2012, lacked documentation to indicate Synthroid 0.05 mg was given at 5:00 a.m. on 05/14/2012 and Zyprexa 15 mg was given at 8:00 p.m. on 05/25/2012.</p> <p>The Physician's orders, dated 05/01/2012-05/31/2012, indicated client #5 received "...Synthroid (hormone replacement) 0.05 mg Once a day...Zyprexa (antipsychotic) 15 mg At bedtime give 1 tab...."</p>						

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	<p>3. Client #6's record was reviewed on 06/26/2012 at 2:30 p.m. Client #6's MAR, dated 04/01/2012-04/30/2012, lacked documentation to indicate Trileptal 600 mg was given at 8:00 p.m. on 04/14/2012.</p> <p>The Physician's orders, dated 04/01/2012-04/30/2012, indicated client #6 received "...Trileptal (seizure medication) 600 mg At bedtime give 1 Tab...."</p> <p>Client #6's MAR, dated 05/01/2012-05/31/2012, lacked documentation to indicate Salex was applied at 8:00 p.m. on 05/12/2012, 05/16/2012, 05/17/2012, 05/24/2012, and 05/25/2012. The record lacked documentation to indicate Trileptal 600 mg was administered at 10:00 p.m. on 05/10/2012 and Nystatin was applied at 8:00 p.m. on 05/10/2012 and 05/16/2012.</p> <p>The Physician's orders, dated 05/01/2012-05/31/2012, indicated client #6 received "...Salex Topical Once a day Apply to crusted areas on scalp... Trileptal 600 mg At bedtime give 1 Tab...Nystatin 100000 Unit/GM (gram) Two times a day apply to jock itch...."</p> <p>During an interview on 06/27/2012 at 10:00 a.m., the Director of Nursing</p>			

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	<p>indicated lack of documentation on the MAR indicated the medication was not administered.</p> <p>During an interview on 06/27/2012 at 11:15 a.m., LPN #11 indicated lack of documentation on the MAR indicated the medication was not administered.</p> <p>During an interview on 06/27/2012 at 11:17 a.m., LPN #12 indicated lack of documentation on the MAR indicated the medication was not administered.</p> <p>4. Client #3's record was reviewed on 6/27/12 at 7:15 AM. Client #3's May 2012 Medication Administration Records (MARs) indicated the following blanks/no initials:</p> <p>-5/16/12 5 PM Acetaminophen (generalized discomfort) 500 milligrams (mg) two times a day -5/16/12 5 PM Docusate Sodium (constipation) 100 mg two times a day -5/16/12 5 PM Neurontin 100 mg (neuropathic pain) two times a day -5/16/12 5 PM Os-cal (calcium) 500 plus Vitamin D two times a day</p> <p>Client #3's May 2012 MAR also indicated client #3's Calzome (barrier) ointment to apply to buttocks three times a day until healed was not administered on the day</p>				

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	<p>shift on 5/15, 5/16 and 5/31/12. Client #3's MAR indicated the Calzyme ointment was not administered on the evening shift on 5/9/12.</p> <p>Client #3's April 2012 MARs indicated client #3's Oscal 500 plus vitamin D was not administered at the 8 AM medication pass on 5/13 and on 5/19/12. Client #3's April 2012 MAR indicated client #3's Peridex rinse (oral hygiene rinse) was not administered at the 8 AM medication pass on 5/13, 5/19 and on 5/24/12. The April 2012 MAR indicated client #3's Acetaminophen, Docusate Sodium and Neurontin were not administered at the 8 AM medication pass on 5/13 and on 5/19/12. Client #3's Calzyme was not administered at the evening medication pass on 4/15, 4/17 and on 4/26/12.</p> <p>Interview with the Director of Nursing (DON) on 6/27/12 at 10:00 AM indicated there should be no blank spaces on client #3's MARs. When asked what the blank spaces meant, the DON stated "Looks like it was not given."</p> <p>5. Client #1's record was reviewed on 6/27/12 at 8:02 AM. Client #1's May 2012 MARs indicated client #1 did not receive her Calcium Carbonate Vitamin D (supplement) two times a day at the 8 AM medication pass on 5/9 and 5/17/12.</p>						

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	<p>Client #1's May 2012 MAR indicated the client did not receive her Docusate Sodium at the 8 AM medication pass on 5/10 and on 5/17/12. Also, client #1 did not receive her Miralax 17 grams in 8 ounce of juice or water (constipation) or Sorbitol 70% solution two times a day for constipation at the 8 AM medication pass on 5/17/12.</p> <p>Interview with the Director of Nursing (DON) on 6/27/12 at 10:00 AM indicated there should be no blank spaces on client #1's MARs. When asked what the blank spaces meant, the DON stated "Looks like it was not given."</p> <p>This federal tag relates to complaint #IN00109013.</p> <p>3.1-25(b)(3) 3.1-25(B)(9)</p>						

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W0381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation and interview, the facility failed to ensure medication carts were locked when unattended by staff while clients (clients #14, #15, #16 and #17) were present in the hallway where the carts were left unattended.</p> <p>Findings include:</p> <p>1. During medication administration observations on 06/27/2012 at 4:30 p.m., LPN #4 left the medication cabinet unlocked and unattended for 2 minutes between passing medications to clients. Client #16 was present in the 2 West hallway where the cart was left unlocked and unattended by staff.</p> <p>During medication administration observations on 06/27/2012 at 4:45 p.m., LPN #4 left the medication cabinet unlocked and unattended for 2 minutes between passing medications to clients. Client #15 was present in the 2 West hallway where the cart was left unlocked and unattended by staff.</p> <p>During an interview on 06/27/2012 at 4:45 p.m., LPN #10 indicated she should</p>	W0381	<p><b><u>W381 Drug Storage and Record keeping</u></b> The facility must store drugs under proper conditions of security. <b><u>I Corrective Action for Cited Clients:</u></b> Nursing has been re-trained on keeping the medication cart locked. <b><u>II Other Clients Potentially at Risk: All residents of North Willow are potentially at risk for this incorrect practice.</u></b> <b><u>III Corrective Measures or Systemic Changes:</u></b> Auditing by Nurse management completed for 30 days to assure compliance. <b><u>IV Monitoring Corrective Measures:</u></b> Follow up including progressive discipline actions are taken when warranted for the medication cart being unlocked and nurse away from it.</p>	07/29/2012			

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	<p>have locked the medication cart before she when she walked away from the area.</p> <p>During an interview on 06/27/2012 at 4:10 p.m., the Director of Nursing indicated the medication carts should not have been left unlocked and unattended by nursing staff.</p> <p>2. During medication administration observation on 6/25/12 at 4:00 PM, RN #1 left the medication cabinet unlocked and unattended for 2 minutes between passing medications to clients. Client #17, client #14 and client #9 were present in the cafeteria where the cart was left unattended.</p> <p>During an interview on 06/27/2012 at 4:10 p.m., the Director of Nursing indicated the medication carts should not have been left unlocked and unattended by nursing staff.</p> <p>3.1-25(m)</p>						