

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  12/21/2012
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 #IN00120976.</p> <p>Complaint #IN00120976: Substantiated, state and federal deficiencies related to the allegation(s) are cited at: W9999, W149, W153, W155 and W156.</p> <p>Dates of Survey: 12/20/12, 12/21/12</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyor, Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2</p> <p>Quality review completed January 4, 2013 by Dotty Walton, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 25 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 1 of 15 sampled clients (D) plus 1 additional client (P), the facility failed to implement its abuse and neglect policy and procedures to ensure the facility immediately notified officials regarding an allegation of sexual misconduct by staff toward client D. The facility failed to implement its abuse and neglect policy and procedures to ensure the facility immediately notified officials regarding emergency medical treatment for client P. The facility failed to implement its abuse and neglect policy and procedures to take steps to protect clients while an allegation of sexual misconduct was investigated for client D. The facility failed to implement its abuse and neglect policy and procedures to report results of an investigation in regards to an allegation of sexual misconduct for client D within 5 working days.</p> <p>Findings include:</p> <p>1. The facility's policy and procedures were reviewed on 12/21/12 at 5:00 PM.</p>	W0149	<p>W149</p> <p>I The two staff who originally informed the Administrator of the issue involving client D have been trained to report exactly what is written on the BIR report in cases where an allegation is presented. When any uncertainty occurs staff will be suspended pending investigation so as to err on the side of caution.</p> <p>The nurse who sent resident P to the hospital emergency room has been trained to print this report and forward it to the Client Advocate office who will assure all outside notifications are completed.</p> <p>II All residents may be affected by these deficient practices.</p> <p>III ED and DNS instructed to request from reporting staff exactly what is written on the BIR when reporting an allegation to them.</p> <p>Nurses have been trained to print reports and forward to the Client Advocate office who will assure all outside notifications are completed.</p> <p>IV Administrator and Director of</p>	01/20/2013			

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	<p>The facility's 6/25/10 policy and procedure entitled, "Reporting Alleged Violations" indicated:</p> <p>-"It is the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriate of resident property ("alleged violations") are reported immediately to the executive director of the facility. Such violations are also reported to state agencies in accordance with existing state law."</p> <p>-"Sexual abuse includes, but is not limited to: sexual harassment, sexual coercion, sexual assault."</p> <p>The facility failed to implement its policy and procedures to ensure the facility immediately notified officials in accordance with state law regarding an allegation of sexual misconduct by staff toward client D. The facility failed to immediately notify officials in accordance with state law regarding emergency medical treatment for client P. Please see W153.</p> <p>2. The facility's policy and procedures were reviewed on 12/21/12 at 5:00 PM. The facility's 6/25/10 policy and</p>		<p>Nursing Services will review in detail each BIR which may involve an allegation of abuse.</p> <p>Client Advocates, Program Directors and Director of Nursing and Assistant Director of Nursing will review progress notes daily to check for needed reports from nursing for those residents who visit the hospital. Completed by 1-20-13</p>				

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	<p>procedure entitled, "Reporting Alleged Violations" indicated:</p> <p>- "If the circumstances require it, the DNS (director of nursing services) or his/her designee removes a resident suspected of being the subject of an alleged violation to an environment where the resident's safety can be protected."</p> <p>- "If the suspected perpetrator is... an associate or family, friend or visitor: The ED (executive director) places the associate on immediate investigatory suspension while completing the investigation. It is explained to the associate that if the investigation results do not require suspension or termination, the associate may be allowed to return to work and any scheduled days missed during the suspension time may be paid."</p> <p>The facility failed to implement its policy and procedures to ensure the facility immediately suspended all staff involved while an incident of sexual misconduct was investigated in regards to client D. Please see W155.</p> <p>3. The facility's policy and procedures were reviewed on 12/21/12 at 5:00 PM. The facility's 6/25/10 policy and procedure entitled, "Reporting Alleged Violations" indicated:</p>				

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	<p>-"The results of all investigations are reported to the ED or designee and to the appropriate state agency, as required by state law, within five working days of the alleged violation."</p> <p>The facility failed to implement its policy and procedures to ensure the facility reported the results of an investigation in regards to an allegation of sexual misconduct for client D within 5 working days. Please see W156.</p> <p>This federal tag relates to complaint #IN00120976.</p> <p>3.1-28(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 25 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 1 of 15 sampled clients (D) plus one additional client (P), the facility failed to immediately notify officials in accordance with state law regarding an allegation of sexual misconduct by staff toward client D. The facility failed to immediately notify officials in accordance with state law regarding emergency medical treatment for client P.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, BIRs (Behavior Incident Reports) and investigations were reviewed on 12/20/12 at 2:02 PM and on 12/21/12 at 9:27 AM. The review indicated the following:</p> <p>-BDDS report dated 12/14/12 indicated on 12/6/12 client P was sent to the ER (emergency room) regarding pitting</p>	W0153	<p>W153</p> <p>I The two staff who originally informed the Administrator of the issue involving client D have been trained to report exactly what is written on the BIR report in cases where an allegation is presented. When any uncertainty occurs staff will be suspended pending investigation so as to err on the side of caution.</p> <p>The nurse who sent resident P to the hospital emergency room has been trained to print this report and forward it to the Client Advocate office who will assure all outside notifications are completed.</p> <p>II All residents may be affected by these deficient practices.</p> <p>III ED and DNS instructed to request from reporting staff exactly what is written on the BIR when reporting an allegation to them.</p> <p>Nurses have been trained to print reports and forward to the Client Advocate office who will assure all outside notifications are</p>	01/20/2013	

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	<p>edema to the left leg.</p> <p>-BIR completed by CNA #1 (certified nurse aid) dated 12/5/12 at 8:45 PM indicated, "[Client D] was coming from the shower; from being bathed by [CNA #1]. As [client D] came into the classroom [client D] saw [CNA #1] and [CNA #5] in the classroom, so [client D] began to come in. As [client D] came into the classroom he said and I quote, 'she asked me if I wanted to have sex in the shower.' When [CNA #1] heard that [CNA #1] couldn't believe [CNA #1's] ears. So, [CNA #1] said, 'What?'"</p> <p>-BIR completed by CNA #5 dated 12/5/12 at 8:30 PM indicated, "[Client D] come from shower room. (sic) [Client D] say the staff (sic) was asking [client D] whether he can have sex (sic)."</p> <p>-BIR completed by CNA #6 dated 12/5/12 at 8:30 PM indicated, "As [CNA #6] entered the first floor West hall classroom I heard [CNA #1] talking to [client D]. It was said that [client D] told [CNA #1] that [client D] got a shower and was asked bout (sic) sex by [CNA #2]."</p> <p>-BDDS report dated 12/12/12 indicated, "On 12/5/12, it was reported that [client D] had made a comment to a CNA that 'she' asked him about having sex in the</p>		<p>completed.</p> <p>IV Administrator and Director of Nursing Services will review in detail each BIR which may involve an allegation of abuse.</p> <p>Client Advocates, Program Directors and Director of Nursing and Assistant Director of Nursing will review progress notes daily to check for needed reports from nursing for those residents who visit the hospital. Completed by 1-20-13</p>		

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	<p>shower. Supervisory nursing staff spoke to the floor nurse and CNAs working at the time and also spoke with [client D]. 'She' was not identified as any specific person or by any relationship to him and [client D] did not report any issues."</p> <p>-Investigation dated 12/14/12 indicated, "On 12/5/12, [RN #1 (registered nurse)] and [NS #1 (nurse supervisor)] and [RN #2] spoke with the CNAs working at the time. [CNA #6] said she did not hear [client D] say anything but heard [CNA #1] asking [client D] of (sic) he made the statement and [client D] said yes."</p> <p>Interview with CNA #1 on 12/26/12 at 12:11 PM indicated she had worked with client D the evening of 12/5/12. CNA #1 indicated client D had exited the shower room after being showered with CNA #6. CNA #1 indicated client D told her he was asked about having sex while in the shower room. CNA #1 stated, "I reported the allegation to RN #2 and NS #1." CNA #1 indicated she completed a BIR regarding the allegation for client D.</p> <p>Interview with CA #1 (client advocate) on 12/20/12 at 12:57 PM indicated allegations of abuse, neglect, mistreatment and/or injuries of unknown origin and emergency medical treatment should be reported to BDDS within 24 hours of the incident.</p>				

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	<p>This federal tag relates to complaint #IN00120976.</p> <p>3.1-13(g)(1) 3.1-28(c)</p>			

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W0155	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 25 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 1 of 15 sampled clients (D), the facility failed to prevent further potential abuse by allowing staff to work with a client while an allegation was investigated.</p> <p>Findings include:</p> <p>The facility's BDDS reports, BIR's (behavior incident report) and investigations were reviewed on 12/20/12 at 2:02 PM and on 12/21/12 at 9:27 AM. The review indicated the following:</p> <p>-BIR completed by CNA #1 (certified nurse aid) dated 12/5/12 at 8:45 PM indicated, "[Client D] was coming from the shower; from being bathed by [CNA #1]. As [client D] came into the classroom [client D] saw [CNA #1] and [CNA #5] in the classroom, so [client D] began to come in. As [client D] came into the classroom he said and I quote, 'she asked me if I wanted to have sex in the shower.' When [CNA #1] heard that [CNA #1] couldn't believe [CNA #1's] ears. So, [CNA #1] said, 'What?'"</p>	W0155	<p>W155</p> <p>I The two staff who originally informed the Administrator of the issue involving client D have been trained to report exactly what is written on the BIR report in cases where an allegation is presented. When any uncertainty occurs staff will be suspended pending investigation so as to err on the side of caution.</p> <p>The nurse who sent resident P to the hospital emergency room has been trained to print this report and forward it to the Client Advocate office who will assure all outside notifications are completed.</p> <p>II All residents may be affected by these deficient practices.</p> <p>III ED and DNS instructed to request from reporting staff exactly what is written on the BIR when reporting an allegation to them.</p> <p>Nurses have been trained to print reports and forward to the Client Advocate office who will assure all outside notifications are completed.</p> <p>IV Administrator and Director of Nursing Services will review in</p>	01/20/2013			

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	<p>-BIR completed by CNA #5 dated 12/5/12 at 8:30 PM indicated, "[Client D] come from shower room. (sic) [Client D] say the staff (sic) was asking [client D] whether he can have sex (sic)."</p> <p>-BIR completed by CNA #6 dated 12/5/12 at 8:30 PM indicated, "As [CNA #6] entered the first floor West hall classroom I heard [CNA #1] talking to [client D]. It was said that [client D] told [CNA #1] that [client D] got a shower and was asked bout (sic) sex by [CNA #2]."</p> <p>-BDDS report dated 12/12/12 indicated, "On 12/5/12, it was reported that [client D] had made a comment to a CNA that "she" asked him abut having sex in the shower. Supervisory nursing staff spoke to the floor nurse and CNAs working at the time and also spoke with [client D]. "She" was not identified as any specific person or by any relationship to him and [client D] did not report any issues."</p> <p>-Investigation dated 12/14/12 indicated, "On 12/5/12, [RN #1 (registered nurse)] and [NS #1 (nurse supervisor)] and [RN #2] spoke with the CNAs working at the time. [CNA #6] said she did not hear [client D] say anything but heard [CNA #1] asking [client D] of (sic) he made the statement and [client D] said yes." The review indicated CNA #6 had not</p>		<p>detail each BIR which may involve an allegation of abuse.</p> <p>Client Advocates, Program Directors and Director of Nursing and Assistant Director of Nursing will review progress notes daily to check for needed reports from nursing for those residents who visit the hospital. Completed by 1-20-13</p>	

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	<p>been suspended or redeployed to another location away from client D during the investigation.</p> <p>Interview with CNA #1 on 12/26/12 at 12:11 PM indicated she had worked with client D the evening of 12/5/12. CNA #1 indicated client D had exited the shower room after being showered with CNA #6. CNA #1 indicated client D told her he was asked about having sex while in the shower room. CNA #1 stated, "I reported the allegation to RN #2 and NS #1." CNA #1 indicated she completed a BIR regarding the allegation for client D. CNA #1 indicated CNA #6 was not suspended or moved to another area away from client D.</p> <p>Interview with PD (program director) #1 on 12/21/12 at 11:15 AM indicated CNA #6 was not suspended or move to another unit during the investigation regarding the allegation of sexual misconduct for client D.</p> <p>This federal tag relates to complaint #IN00120976.</p> <p>3.1-28(d)</p>						

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 25 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 1 of 15 sampled clients (D), the facility failed to report the results of an investigation in regards to an allegation of sexual misconduct for client D to the administrator or other officials within 5 working days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, BIRs (Behavior Incident Reports) and investigations were reviewed on 12/20/12 at 2:02 PM and on 12/21/12 at 9:27 AM. The review indicated the following:</p> <p>-BIR completed by CNA #1 (certified nurse aid) dated 12/5/12 at 8:45 PM indicated, "[Client D] was coming from the shower; from being bathed by [CNA #1]. As [client D] came into the classroom [client D] saw [CNA #1] and [CNA #5] in the classroom, so [client D] began to come in. As [client D] came into</p>	W0156	<p>W156 I The two staff who originally informed the Administrator of the issue involving client D have been trained to report exactly what is written on the BIR report in cases where an allegation is presented. When any uncertainty occurs staff will be suspended pending investigation so as to err on the side of caution.</p> <p>The nurse who sent resident P to the hospital emergency room has been trained to print this report and forward it to the Client Advocate office who will assure all outside notifications are completed.</p> <p>II All residents may be affected by these deficient practices.</p> <p>III ED and DNS instructed to request from reporting staff exactly what is written on the BIR when reporting an allegation to them.</p> <p>Nurses have been trained to print reports and forward to the Client Advocate office who will assure all outside notifications are completed.</p>	01/20/2013			

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	<p>the classroom he said and I quote, 'she asked me if I wanted to have sex in the shower.' When [CNA #1] heard that [CNA #1] couldn't believe [CNA #1's] ears. So, [CNA #1] said, 'What?'"</p> <p>-BIR completed by CNA #5 dated 12/5/12 at 8:30 PM indicated, "[Client D] come from shower room. (sic) [Client D] say the staff (sic) was asking [client D] whether he can have sex (sic)."</p> <p>-BIR completed by CNA #6 dated 12/5/12 at 8:30 PM indicated, "As [CNA #6] entered the first floor West hall classroom I heard [CNA #1] talking to [client D]. It was said that [client D] told [CNA #1] that [client D] got a shower and was asked bout (sic) sex by [CNA #2]."</p> <p>-BDDS report dated 12/12/12 indicated, "On 12/5/12, it was reported that [client D] had made a comment to a CNA that 'she' asked him abut having sex in the shower. Supervisory nursing staff spoke to the floor nurse and CNAs working at the time and also spoke with [client D]. 'She' was not identified as any specific person or by any relationship to him and [client D] did not report any issues."</p> <p>-Investigation dated 12/14/12 indicated, "On 12/5/12, [RN #1 (registered nurse)] and [NS #1 (nurse supervisor)] and [RN</p>		<p>IV Administrator and Director of Nursing Services will review in detail each BIR which may involve an allegation of abuse.</p> <p>Client Advocates, Program Directors and Director of Nursing and Assistant Director of Nursing will review progress notes daily to check for needed reports from nursing for those residents who visit the hospital. Completed by 1-20-13</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  12/21/2012	
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	<p>#2] spoke with the CNAs working at the time. [CNA #6] said she did not hear [client D] say anything but heard [CNA #1] asking [client D] of (sic) he made the statement and [client D] said yes." The investigation indicated the date of the allegation was 12/5/12 and the date of completion of the investigation was 12/14/12.</p> <p>Interview with PD (program director) #1 on 12/21/12 at 11:15 AM indicated investigation of allegations of abuse, neglect, mistreatment and injuries of unknown origin should be completed/reported within 5 working days of the date of the allegation.</p> <p>This federal tag relates to complaint #IN00120976.</p> <p>3.1-28(e)</p>						

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W9999	<p>STATE FINDINGS:</p> <p>The following Comprehensive Care Facility rules was not met:</p> <p>410 IAC 16.2-3.1-14 PERSONNEL</p> <p>Sec. 14(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review for 1 of 3 personnel records reviewed, the facility failed to obtain reference checks for CNA #1 (certified nurses aid).</p> <p>Findings include:</p> <p>CNA #1's employee file was reviewed on 12/21/12 at 10:25 AM. CNA #1's employee file contained no documentation of reference checks.</p>	W9999	<p>W9999</p> <p>I Review of current employee files have been completed to assure at least 2 references for each current employee is in place and when missing additional references have been sought so that each employee will have at least 2 references. Going forward 3 are expected.</p> <p>II All residents may be affected by these deficient practices.</p> <p>III The Director of Clinical Education and Receptionist have been trained that 3 references must be obtained for each prospective employee.</p> <p>IV The Administrator will review new hire packets to assure that 3 references have been obtained for each person hired. Completed by 1-20-13</p>	01/20/2013			

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	<p>Interview with CA #1 (client advocate) on 12/20/12 at 12:57 PM indicated the facility conducted reference checks on employees as part of the facility's system to protect clients form abuse, neglect and mistreatment.</p> <p>Interview with PD (program director) #1 on 12/21/12 at 11:15 AM indicated there were no additional employee reference check forms available to review regarding CNA #1.</p> <p>This state tag relates to complaint #IN00120976.</p> <p>3.1-14(a)</p>				