

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  07/22/2013
--	---	--	---

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
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: 7/8, 7/9, 7/10, 7/11, 7/12, 7/15, 7/16 and 7/22/13</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyors: Paula Chika, QIDP-TC Vickie Kolb, RN Susan Eakright, QIDP Tim Shebel, LSW Keith Briner, QIDP Christine Colon, QIDP Susan Reichert, QIDP Kathy Wanner, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 7/26/13 by Ruth Shackelford, QIDP.</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.

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  07/22/2013
--	---	--	---

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

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  07/22/2013	
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			
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 15 of 15 sampled clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15) and for 133 additional clients (#16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148). The governing body failed to ensure the facility implemented its written policy and procedures: to prevent neglect of client #76 in regards to a fall which resulted in a head injury, to</p>	W000102	<p>Annual Survey 7/22/13</p> <p>W102 QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Client #76's IDT will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid. For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out</p>	08/21/2013			

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  07/22/2013	
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>monitor/supervise client #76 in regard to the client's history of falls, to implement safeguards to prevent client #76 from further injury due to reoccurring falls and to ensure nursing services obtained timely medical services for client #76 to rule out potential traumatic head injury due to a fall which resulted in an Immediate Jeopardy. The governing body failed to ensure all clients participated in activities in the community (#1, #2, #3, #4, #5, #8 and #9), reported allegations of abuse, neglect and/or injuries of unknown source timely (#20, #27, #71, #73, #76, #94, #96, #118, #135 and #141), conducted thorough investigations of allegations of abuse, neglect and/or injuries of unknown source/fractures (#15, #16 and #55), and removed a staff person from client contact once an allegation was made (#141). The governing body failed to implement its policy and procedures to prevent neglect and/or abuse of clients (#37, #76 #132, #141 and #149). The governing body failed to ensure a client's pop money was reimbursed, and to ensure the facility developed a diabetic protocol in regard to the administration of insulin.</p> <p>Based on observation, interview and record review for 11 of 15 sampled clients (#1, #2, #3, #4, #5, #9, #11, #12, #13, #14 and #15) and 51 additional clients (#23, #99, #100, #101, #102, #103, #104, #105,</p>		<p>potential traumatic head, or other, injury are specified.. Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed</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  07/22/2013
--	---	--	---

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>#106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148), the governing body failed to ensure its Health Care Services met the nursing needs of clients in regard to obtaining timely medical services for a client with a head injury, monitoring a client's skin integrity issues, to ensure an ill client was monitored to prevent further injury, to ensure repositioning schedules were present, ensuring medications were received as ordered, and clients returned to doctors/audiologist as recommended. The governing body failed to ensure its Health Care Services conducted quarterly nursing assessments, administered medications without error and to ensure all medications were locked/secured.</p> <p>The governing body failed to maintain the dresser of client #127, to clean the windows in the dining room and rooms 331, 332, 333, 335, and 337 which affected clients #11, #12, #13, #14, #15, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129,</p>		<p>after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility and (b) requiring additional evaluation (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</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  07/22/2013
--	---	--	---

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>#130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148; to remove water from the dining room steam table which affected clients #11, #12, #13, #14, #15, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148. The governing body failed to ensure its dietary equipment was maintained/repared, old food was discarded for all 148 clients in the building, to ensure the facility's ice machines were cleaned on a regular basis, and to ensure clients' bathroom and ceiling vents were properly maintained for clients #13, #106, #110 and #111.</p> <p>Findings include:</p> <p>1. Based on observation, interview and record review, the governing body failed to ensure the facility met the Condition of Participation: Client Protections for 8 of 15 sampled clients (#1, #2, #3, #4, #5, #8, #9 and #15) and for 14 additional clients (#16, #20, #27, #37, #55, #71, #73, #76, #94, #118, #132, #135, #141 and #149). The governing body failed to ensure all</p>		<p>Staff for resident 76 have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>For the individual who knocked over #149's wheelchair, antecedents and reactive interventions for AWOL in her BSP will be reviewed. Staff who work with her will be retrained on the BSP.</p> <p>Reinstitute the flow chart: BIR/Fall Assessment -resident 76s Nurse has been trained on flow chart to determine if need to call ED - BIR box for follow-up.</p> <p>Client #37's IDT did meet to review her dining plans and risks. PD or Q will review outing form for completeness and accuracy, staffing levels, etc. The outing form is taken by staff for reference during the activity. Recreation staff will receive training specific to Client #37's diet. Staff who working directly with client #37 have been trained on the Heimlich and training to competency.</p> <p>Client #132's IDT to met and</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  07/22/2013
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>clients participated in activities in the community, reported allegations of abuse, neglect and/or injuries of unknown source timely, conducted thorough investigations, and removed a staff person from client contact once an allegation was made. The governing body failed to implement its policy and procedures to prevent neglect and/or abuse of clients who lived in the facility. Please see W122.</p> <p>2. Based on observation, interview and record review, the governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 11 of 15 sampled clients (#1, #2, #3, #4, #5, #9, #11, #12, #13, #14 and #15) and 51 additional clients (#23, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148). The governing body failed to ensure its Health Care Services failed met the nursing needs of clients in regard to obtaining timely medical services for a client with a head injury, monitoring a client's skin integrity issues, to ensure an ill client was monitored to prevent further</p>		<p>review her fall care/risk plan and her BSP (for relationship between behavioral incident and fall) for compatibility with her most recent evaluations/recommendations. Recommendations on her current care plan will be reviewed and any that are outdated Any updates/revisions made will be added to her CST and nursing and CNA staff will be retrained on those revisions. Housekeeping staff will be inserviced to refrain from mopping floors in rooms where clients are present. Inservice training will include contacting the QIDP or PD of the floor for assistance if there is a need to mop immediately.</p> <p>Client #132's IDT will meet to determine a nail care regimen for her and if a formal goal is needed to assure completion. For any clients for whom there have been injuries associated with nail care (scratches/unknown injuries) in the past 6 months, their IDTs will meet and develop similar regimens/recommendations.</p> <p>Client #132's IDT will meet to discuss falls occurring at night and develop interventions that can provide additional protections for her. Defining remote supervision will be included in the development of those plans.</p> <p>For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated. With</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  07/22/2013
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>injury, to ensure repositioning schedules were present, ensuring medications were received as ordered, and clients returned to doctors/audiologist as recommended. The governing body body failed to ensure its Health care services conducted quarterly nursing assessments, administered medications without error and to ensure all medications were locked/secured. Please see W318.</p> <p>3. The governing body failed to ensure the facility maintained/repared vents, dietary equipment, toilets and the facility in general to ensure the facility was in good repair. The governing body failed to ensure no outdated foods were housed/kept in the facility.</p> <p>The governing body failed to ensure the facility implemented its policy and procedures to ensure safeguards were implemented to prevent client #76 from further injury due to falls, to monitor/supervise client #76 after a fall resulting in a head injury and to provide client #76 with timely medical services to rule out potential traumatic head injury due to a fall which resulted in an Immediate Jeopardy. The governing body failed to ensure client #149 was monitored/supervised to prevent client to client abuse resulting in a head injury requiring immediate medical attention of</p>		<p>regard to resident 141staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>For residents 1, 2, 3, 4, and 5 QMRP and Program Director who serves them has been retrained on the Community Integration Policy for North Willow. This policy was approved in POCs for surveys ID: CRT311 and ID: CTR312 respectively.</p> <p>For all those residents sited QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Nurse for resident 86 has been in-serviced on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</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  07/22/2013	
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>911. The governing body failed to ensure the facility's administrator recognized an allegation of verbal abuse involving client #141, reported the abuse to state officials timely, suspended staff to protect clients, and/or failed to initiate an investigation of the staff's interactions with clients to ensure clients were not subjected to abuse. The governing body failed to ensure facility staff reported injuries of unknown source to the administrator timely for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. The governing body failed to prevent exploitation of client #141 in regard to the use of the client's pop money. The governing body failed to prevent neglect of client #37 in regard to a choking incident, and in regard to falls involving client #132 which resulted in injuries/trips to the emergency room. The governing body failed to ensure the facility conducted thorough investigations in regard to client #15, #16 and #55's fractures.</p> <p>The governing body failed to ensure the clients participated in activities in the community on a regular and/or ongoing basis in regard to clients #1, #2, #3, #4, #5, #8 and #9.</p> <p>The governing body failed to ensure all allegations of abuse, neglect and/or</p>		<p>Nurse for residents sited have been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>Nurse for residents sited have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>Nurse for residents sited have been in-serviced to include clear, concise documentation when following a patient's plan of care.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Re-positioning schedule for client #9 has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling including client 9 will be evaluated for the appropriate size sling and how to safely position</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  07/22/2013
--	---	--	---

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>injuries of unknown source were immediately reported to the administrator and/or to state officials per state law for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. The governing body failed to ensure the facility conducted thorough investigations in regard to injuries of unknown source/fractures for clients #15, #16 and #55. The governing body failed to ensure a professional staff person was immediately suspended in regard to an allegation of verbal abuse for client #141.</p> <p>The governing body failed to ensure the facility's Health Care Services met the nursing needs of clients to provide client #76 with timely medical services to rule out potential head injury due to fall, monitored/supervised client #76 after a fall resulting in a head injury and instructed the direct care staff in supervising/monitoring and providing client #76 health care in regard to falls with head injury. The governing body failed to ensure its nursing services assessed/monitored client #86 due to skin ulcerations and ensured the staff followed the client's plan of care and documented the client's information, supervised and monitored client #149 to prevent injury resulting in a head injury due to client abuse, repositioned client #9 every 2 hours and documented the position she</p>		<p>the sling. Nursing services will complete a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed Medical Director has screened residents 1, 3 and 4's hearing and documented on their annual physical.</p> <p>Nurse for client 2 will monitor vital signs and lung sounds each shift due to risk for aspiration due to emesis during seizures.</p> <p>Resident 1 has a physician order that states Keppra may be crushed.</p> <p>Resident number 23's orders have been reviewed to assure medication is given as prescribed.</p> <p>Nurse for residents 2 and 4 now have updated nursing quarterlies and annuals.</p> <p>Resident 2's nurse has been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</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  07/22/2013	
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>was placed in on the positioning schedule. The governing body failed to ensure its nursing services administered clients #1 and #23's medications as ordered, and to obtain follow-up medical appointments for clients #1 and #3.</p> <p>The governing body failed to ensure its nursing services conducted quarterly nursing assessments of clients' health status and medical needs for clients #2, #3 and #4. The governing body failed to ensure its nursing services ensured all medications were administered without error for 3 of 40 doses administered for clients #24, #71 and #72.</p> <p>The governing body failed to ensure its nursing services locked all medications until ready for administration which affected 5 of 15 sampled clients (clients #11, #12, #13, #14, and #15) and 50 of 133 additional clients (clients #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) who lived on the third floor of the facility. Please see W104.</p>		<p>The Housekeeping Staff will complete a "Cleaning List" for the ice machine daily. The Housekeeping Supervisor will review the "Cleaning List" daily and report any ice machine maintenance issues to the ED immediately for repair. Housekeeping staff will be trained on the "Cleaning List."</p> <p>Steam table has been repaired.</p> <p>Staff for sited residents have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>Sanitizing unit installed in kitchen for use between dirty side and hand sink. ADD/designee assures gloves are available for use in kitchen. Residents 107 and 148 have been assessed by their IDT as to individual interventions for drooling and those interventions are implemented. Dietary must follow the following procedure when going from dirty to clean side of kitchen.</p> <ol style="list-style-type: none"> <li>1.Wear gloves on dirty side</li> <li>2.to go to clean side, remove gloves and use hand sanitizer</li> <li>3.go to hand sink and wash hands with soap and water rubbing for 20 seconds washing thoroughly</li> <li>4.Dry hands, turn off water with</li> </ol>				

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  07/22/2013
--	---	--	---

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>towel and discard.</p> <p>Follow menu and provide foods as per guidelines. Do not mix foods together such as scrambled eggs and Banana bread. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff who was P-2 trained that it was his task to report and discard outdated food. When out of date food is found it will be discarded, report this to the ADD. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service. Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Hot coffee to be served per Golden Living Policy. Measure temperature prior to taking food and drinks to the floor. Coffee should be served per North Willow policy.. Resident 37 has had her dining</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  07/22/2013
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>plan reviewed, her dining goal reviewed. The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is listed on the form as well as instruction that if there is a change or any problem in staff attending, the supervisor will be contacted for direction. Dietary staff have been trained to follow menu and provide correct menued items for resident 9. Though staff are certain resident 4 received his regular diet, staff have been trained to assure resident 4 receives his prescribed diet. Resident 1's staff have been retrained to assure he receives his prescribed diet and double portions as prescribed.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Administrative, supervisory and nursing staff to be retrained on the policy with any changes/revisions highlighted. CNA and other support staff will be retrained on the falls procedure including where fall risk information is maintained and what follow-up expectations are in place. For those individuals with a history of multiple falls or falls with significant injury (requiring more than in-house 1st aid), the IDTs will meet to review existing</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  07/22/2013
--	---	--	---

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>care (risk) plans to assure they are current, reflect most recent PT/professional recommendations and clarify expectations during the period following the fall and prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. Revised fall procedure to be educated with staff. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>Staff have been retrained on identification and reporting of abuse and neglect.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nursing staff have been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing has been trained to notify ED <u>and</u> DNS/ANDS/Designee immediately following fall with assessment.</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  07/22/2013
--	---	--	---

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>Nursing staff have been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion.</p> <p>The fall assessment will be used by the IDT to assist in development or revision of the fall prevention/safe ambulation plan when needed. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. Administrative, supervisory and nursing staff are to be retrained on the reviewed/ revised abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse.</p> <p>Allegations of staff misconduct related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures are in place, that the Executive Director or designee has been notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>Nurses have been trained to implement level of supervision of ill residents, especially with regard to those going to ER and</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  07/22/2013
--	---	--	---

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>instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>For all clients with AWOL and/or physical assault in their plans, the BSPs will be reviewed for appropriateness. CST will be reviewed to monitor that current information/interventions are included.</p> <p>Nurses trained on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>For all clients with identified choking risks, the PD or Q will review the outing form for completeness and accuracy in diet orders, staffing levels, etc. The outing form is taken by staff for reference during the activity. If there are additional dining risks (i.e.: individual compliance), that information will also be noted on the outing form. Staff have been trained on the Heimlich and training to competency will be completed by staff annually. Monitoring for implementation of behavior support plans will be added to the active treatment observations done by the QIDP. The fall care/risk plans for any individual with a history of falls at night (multiple falls or falls with injury) will be reviewed by the IDTs for inclusion of interventions</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  07/22/2013
--	---	--	---

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>specific to this need. Nursing and CNA staff will be retrained on any revisions, and revisions will be updated on the CST.</p> <p>Clients with a fall risk plan will have their shoes assessed for appropriateness and fit. The use of gripper socks will be encouraged and staff will be inserviced on the need to complete a BIR for refusal to follow fall prevention protocols. As part of active treatment training, CNAs will be inserviced on the need to keep people awake in classrooms and common areas and methods to help prevent people from sleeping in chairs.</p> <p>An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of documentation, staff interviews (from all 3 shifts if the fall/injury was not observed), and a conclusion including what is being done to help prevent reoccurrence.</p> <p>Staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. Staff have been retrained to assist in</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  07/22/2013
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>cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QMRP and Program Directors have been retrained on the Community Integration Policy for North Willow.</p> <p>Nursing has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Nurses have been trained on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</p> <p>Re-positioning schedule those who need repositioning has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Annually at time of physical Medical Director or other physician who performs annual physical will screen and document hearing for each resident. North Willow now has a policy that identifies this screen as our practice. Any issues with the screen and the physician may refer resident to Audiologist.</p> <p>Nursing has been in-serviced on Medication. Administration to</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  07/22/2013
--	---	--	---

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>ensure medications are passed without error.</p> <p>Nursing has been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis. Nursing has been in-serviced to include clear, concise documentation when following a patient's plan of care. Re-positioning schedule for clients who need them were developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as</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  07/22/2013
--	---	--	---

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>well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed</p> <p>Nurses for residents who have emesis during seizures will monitor vital signs and lung sounds each shift due to risk for aspiration.</p> <p>Residents who are prescribed Keppra and need their medication crushed now have an order that states Keppra may be crushed.</p> <p>Residents who take medications have had their orders reviewed to assure medication is given as prescribed. Nursing has been retrained on giving medication as prescribed.</p> <p>Updated Do Not Crush List is located in each MAR.</p> <p>Nursing will be retrained on completing quarterlies and annuals on a timely basis.</p> <p>Nurses have been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>The Housekeeping Supervisor will complete a daily Checklist and report any maintenance issues to the ED immediately for repair. Housekeeping Supervisor will be trained on the Checklist.</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  07/22/2013
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>The QDDP or designee will complete "Infection Control" retraining with staff including issues that need to be addressed immediately, cleaning up after clients/ encourage clients to clean up after themselves, and how to report issues to cleaning services.</p> <p>The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time of the observation.</p> <p>Staff have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>Dietary employees were trained to use gloves on the dirty side of the kitchen, remove gloves when leaving dirty and going to clean side, using sanitizer, enter clean side and wash hands at hand sink prior to working on the clean side of kitchen. Recreation will utilize wipes for hand washing or assist resident as needed to wash their hands prior to touching equipment that is being used by multiple residents and their hands are soiled. Residents who drool have been assessed by the IDT as to their need for individual interventions to assist with maintaining sanitation around drooling. ADD to observe for</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  07/22/2013
--	---	--	---

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>procedure of glove use and hand sanitizing and hand washing. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff trained P-2 trained that it was his task to report and discard outdated food. Dietary staff trained to chart Dishwasher temperatures on log as required. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be at the temperature stated in the North Willow policy. ED has observed ADD in inputting a work order in building engines to assure she understands and can input order. The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is</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  07/22/2013
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>listed on the form as well as instruction that if there is a change or any problem in staff attending, the supervisor will be contacted for direction. Dietary staff have been retrained to follow menu and provide correct menued items. Staff have been retrained to provide prescribed diets including portion sizes.</p> <p>IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Client Advocates will assure process followed when there are cases of allegation of neglect and abuse with follow up with ED/DNS when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC</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  07/22/2013
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>Director.</p> <p>QIDPs will monitor documentation folders to check that current BSPs are in the classrooms for ready access by CNAs. QIDPs will add monitoring for the appropriate implementation of BSPs and this monitoring will be added to the active treatment sheets.</p> <p>Diet orders, care/risk plans, dining books and CST will be updated following any change to diet orders. Staff will need to sign off on updated information.</p> <p>Program Directors review outings as to effectiveness, safety and client interest both before and after the trip.</p> <p>Fall risk plans for those at high risk for falls are reviewed by the Client Advocates for quality assurance purposes.</p> <p>Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval.</p> <p>THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved.</p> <p>The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide</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  07/22/2013
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>feedback to the staff at the time of the observation. Rounds include resident appearance and cleanliness.</p> <p>The PD will review the Environmental Round observations weekly and complete retraining as needed. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director. DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis. Active Treatment audits completed by QMRPs and transfer observations will include proper sling use. DCE/DNS/ADNS will audit care plans for those using slings at least quarterly. Health Information Management completes weekly audits that include nursing quarterlies and annuals, DCE, DNS, and ADNS follow up on deficiencies noted on these reports. Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Nursing to audit 15 minute checks each shift to ensure documentation. QMRP to</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  07/22/2013
--	---	--	---

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>audit daily to assure 15 minute documentation.</p> <p>The PD will review the Environmental Round observations weekly and complete retraining as needed. Corrections to be completed by . ADD/Designee observes daily to assure glove use/hand washing procedure is followed properly in the kitchen. QMRPs have been educated to observe their caseload and when issues such as drooling occur, they must implement interventions to assist with the sanitation and dignity issues with it. Program Directors assure QMRP staff assess, develop and implement those interventions. ADD will check dishes to assure dry, assure that P-2 tasks are completed including checking for dates on foods to assure they are not out dated. ADD will input work orders in building engines. ADD checks temperature log for dishwasher. ADD checks cleanliness of cart shelves. Completed by. Out trip forms are reviewed prior to trips being taken to assure correct information is present and staff have been trained on the form and trip procedure. Dining monitors have been retrained to observe and ensure diets are checked by direct care staff and those diets are followed including portion sizes. Completed by 8-21-13.</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  07/22/2013	
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			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 8 of 15 sampled clients (#1, #2, #3, #4, #5, #8, #9 and #15) and for 14 additional clients (#16, #20, #27, #37, #55, #71, #73, #76, #94, #118, #132, #135, #141 and #149), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures: to prevent neglect of client #76 in regards to a fall which resulted in a head injury, to monitor/supervise client #76 in regard to the client's history of falls, to implement safeguards to prevent client #76 from further injury due to reoccurring falls and to ensure nursing services obtained timely medical services for client #76 to rule out potential traumatic head injury due to a fall which resulted in an Immediate Jeopardy. The governing body failed to exercise general policy and operating direction over the facility to ensure all clients participated in activities in the community (#1, #2, #3, #4, #5, #8 and #9), reported allegations of abuse, neglect and/or injuries of unknown source timely (#20, #27, #71, #73, #76, #94, #96, #118, #135 and #141), conducted thorough investigations of allegations of abuse,</p>	W000104	<p>W104</p> <p>QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall.</p> <p>QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other,</p>	08/21/2013			

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  07/22/2013	
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>neglect and/or injuries of unknown source/fractures (#15, #16 and #55), and removed a staff person from client contact once an allegation was made (#141). The governing body failed to exercise general policy and operating direction over the facility to implement its policy and procedures to prevent neglect and/or abuse of clients (#37, #76 #132, #141 and #149). The governing body failed to exercise general policy and operating direction over the facility to ensure a client's pop money was reimbursed, and to ensure the facility developed a diabetic protocol in regard to the administration of insulin.</p> <p>Based on observation, interview and record review for 11 of 15 sampled clients (#1, #2, #3, #4, #5, #9, #11, #12, #13, #14 and #15) and 51 additional clients (#23, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148), the governing body failed to exercise general policy and operating direction over the facility to ensure its Health Care Services met the nursing needs of clients in regard to obtaining</p>		<p>injury are specified.. Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee</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  07/22/2013	
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>timely medical services for a client with a head injury, monitoring a client's skin integrity issues, to ensure an ill client was monitored to prevent further injury, to ensure repositioning schedules were present, ensuring medications were received as ordered, and clients returned to doctors/audiologist as recommended. The governing body failed to exercise general policy and operating direction over the facility to ensure its Health Care Services conducted quarterly nursing assessments, administered medications without error and to ensure all medications were locked/secured.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general policy, budget and operating direction over the facility for 15 of 15 sampled clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15) and for 133 additional clients (#16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103,</p>		<p>and has been trained with staff.</p> <p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan.</p> <p>QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility and (b) requiring additional evaluation (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>Staff for resident 76 have been</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  07/22/2013
--	---	--	---

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
	#104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148). The governing body failed to exercise general policy and operating direction over the facility to maintain the dresser of client #127, to clean the windows in the dining room and rooms 331, 332, 333, 335, and 337 which affected clients #11, #12, #13, #14, #15, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148; to remove water from the dining room steam table which affected clients #11, #12, #13, #14, #15, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148. The governing body failed to exercise general		<p>retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>For the individual who knocked over #149's wheelchair, antecedents and reactive interventions for AWOL in her BSP will be reviewed. Staff who work with her will be retrained on the BSP.</p> <p>Reinstitute the flow chart: BIR/Fall Assessment -resident 76s Nurse has been trained on flow chart to determine if need to call ED - BIR box for follow-up.</p> <p>Client #37's IDT did meet to review her dining plans and risks. PD or Q will review outing form for completeness and accuracy, staffing levels, etc. The outing form is taken by staff for reference during the activity. Recreation staff will receive training specific to Client #37's diet. Staff who working directly with client #37 have been trained on the Heimlich and training to competency.</p> <p>Client #132's IDT to met and review her fall care/risk plan and</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  07/22/2013
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>policy, budget and operating direction over the facility to ensure its dietary equipment was maintained/repared, old food was discarded for all 148 clients in the building, to ensure the facility's ice machines were cleaned on a regular basis, and to ensure clients' bathroom and ceiling vents were properly maintained for clients #13, #106, #110 and #111.</p> <p>Findings include:</p>		<p>her BSP (for relationship between behavioral incident and fall) for compatibility with her most recent evaluations/recommendations. Recommendations on her current care plan will be reviewed and any that are outdated Any updates/revisions made will be added to her CST and nursing and CNA staff will be retrained on those revisions. Housekeeping staff will be inserviced to refrain from mopping floors in rooms where clients are present. Inservice training will include contacting the QIDP or PD of the floor for assistance if there is a need to mop immediately.</p> <p>Client #132's IDT will meet to determine a nail care regimen for her and if a formal goal is needed to assure completion. For any clients for whom there have been injuries associated with nail care (scratches/unknown injuries) in the past 6 months, their IDTs will meet and develop similar regimens/recommendations.</p> <p>Client #132's IDT will meet to discuss falls occurring at night and develop interventions that can provide additional protections for her. Defining remote supervision will be included in the development of those plans.</p> <p>For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated. With regard to resident 141staff will be</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  07/22/2013
--	---	--	---

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>retrained that they cannot use other people's money for any reason without OK from PD/business office.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>For residents 1, 2, 3, 4, and 5 QMRP and Program Director who serves them has been retrained on the Community Integration Policy for North Willow. This policy was approved in POCs for surveys ID: CRT311 and ID: CTR312 respectively.</p> <p>For all those residents sited QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Nurse for resident 86 has been in-serviced on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</p> <p>Nurse for residents sited have</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  07/22/2013
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>been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>Nurse for residents sited have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>Nurse for residents sited have been in-serviced to include clear, concise documentation when following a patient's plan of care.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Re-positioning schedule for client #9 has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling including client 9 will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will</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  07/22/2013
--	---	--	---

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>complete a a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed</p> <p>Medical Director has screened residents 1, 3 and 4's hearing and documented on their annual physical.</p> <p>Nurse for client 2 will monitor vital signs and lung sounds each shift due to risk for aspiration due to emesis during seizures.</p> <p>Resident 1 has a physician order that states Kepra may be crushed.</p> <p>Resident number 23's orders have been reviewed to assure medication is given as prescribed.</p> <p>Nurse for residents 2 and 4 now have updated nursing quarterlies and annuals.</p> <p>Resident 2's nurse has been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>The Housekeeping Staff will</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  07/22/2013
--	---	--	---

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>complete a "Cleaning List" for the ice machine daily. The Housekeeping Supervisor will review the "Cleaning List" daily and report any ice machine maintenance issues to the ED immediately for repair. Housekeeping staff will be trained on the "Cleaning List."</p> <p>Steam table has been repaired.</p> <p>Staff for sited residents have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>Sanitizing unit installed in kitchen for use between dirty side and hand sink. ADD/designee assures gloves are available for use in kitchen. Residents 107 and 148 have been assessed by their IDT as to individual interventions for drooling and those interventions are implemented. Dietary must follow the following procedure when going from dirty to clean side of kitchen.</p> <ol style="list-style-type: none"> <li>1.Wear gloves on dirty side</li> <li>2.to go to clean side, remove gloves and use hand sanitizer</li> <li>3.go to hand sink and wash hands with soap and water rubbing for 20 seconds washing thoroughly</li> <li>4.Dry hands, turn off water with towel and discard.</li> </ol>	

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  07/22/2013
--	---	--	---

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>Follow menu and provide foods as per guidelines. Do not mix foods together such as scrambled eggs and Banana bread.</p> <p>This check for dates is part of the P-2 Dietary Aide task list. Dietary staff who was P-2 trained that it was his task to report and discard outdated food.</p> <p>When out of date food is found it will be discarded, report this to the ADD.</p> <p>Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done.</p> <p>Dietary responsible for charting Dishwasher temperatures trained to chart on log as required.</p> <p>Dishes must be clean and dry. Do not send wet dishes to the floor for service.</p> <p>Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Hot coffee to be served per Golden Living Policy. Measure temperature prior to taking food and drinks to the floor. Coffee should be served per North Willow policy..</p> <p>Resident 37 has had her dining plan reviewed, her dining goal</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  07/22/2013
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>reviewed. The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is listed on the form as well as instruction that if there is a change or any problem in staff attending, the supervisor will be contacted for direction. Dietary staff have been trained to follow menu and provide correct menued items for resident 9. Though staff are certain resident 4 received his regular diet, staff have been trained to assure resident 4 receives his prescribed diet. Resident 1's staff have been retrained to assure he receives his prescribed diet and double portions as prescribed.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Administrative, supervisory and nursing staff to be retrained on the policy with any changes/revisions highlighted. CNA and other support staff will be retrained on the falls procedure including where fall risk information is maintained and what follow-up expectations are in place. For those individuals with a history of multiple falls or falls with significant injury (requiring more than in-house 1st aid), the IDTs will meet to review existing care (risk) plans to assure they</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  07/22/2013
--	---	--	---

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>are current, reflect most recent PT/professional recommendations and clarify expectations during the period following the fall and prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. Revised fall procedure to be educated with staff. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>Staff have been retrained on identification and reporting of abuse and neglect.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nursing staff have been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nursing staff have been trained to</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  07/22/2013
--	---	--	---

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>call 911 when there is a head injury/trauma that is beyond a superficial abrasion.</p> <p>The fall assessment will be used by the IDT to assist in development or revision of the fall prevention/safe ambulation plan when needed. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. Administrative, supervisory and nursing staff are to be retrained on the reviewed/ revised abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse. Allegations of staff misconduct related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures are in place, that the Executive Director or designee has been notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>Nurses have been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level</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  07/22/2013
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>of supervision is to be given due to illness/injury.</p> <p>For all clients with AWOL and/or physical assault in their plans, the BSPs will be reviewed for appropriateness. CST will be reviewed to monitor that current information/interventions are included.</p> <p>Nurses trained on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>For all clients with identified choking risks, the PD or Q will review the outing form for completeness and accuracy in diet orders, staffing levels, etc. The outing form is taken by staff for reference during the activity. If there are additional dining risks (i.e.: individual compliance), that information will also be noted on the outing form. Staff have been trained on the Heimlich and training to competency will be completed by staff annually. Monitoring for implementation of behavior support plans will be added to the active treatment observations done by the QIDP. The fall care/risk plans for any individual with a history of falls at night (multiple falls or falls with injury) will be reviewed by the IDTs for inclusion of interventions specific to this need. Nursing and</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  07/22/2013
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>CNA staff will be retrained on any revisions, and revisions will be updated on the CST.</p> <p>Clients with a fall risk plan will have their shoes assessed for appropriateness and fit. The use of gripper socks will be encouraged and staff will be inserviced on the need to complete a BIR for refusal to follow fall prevention protocols. As part of active treatment training, CNAs will be inserviced on the need to keep people awake in classrooms and common areas and methods to help prevent people from sleeping in chairs.</p> <p>An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of documentation, staff interviews (from all 3 shifts if the fall/injury was not observed), and a conclusion including what is being done to help prevent reoccurrence.</p> <p>Staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. Staff have been retrained to assist in cleaning up a resident who has</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  07/22/2013
--	---	--	---

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>blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QMRP and Program Directors have been retrained on the Community Integration Policy for North Willow.</p> <p>Nursing has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Nurses have been trained on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</p> <p>Re-positioning schedule those who need repositioning has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Annually at time of physical Medical Director or other physician who performs annual physical will screen and document hearing for each resident. North Willow now has a policy that identifies this screen as our practice. Any issues with the screen and the physician may refer resident to Audiologist.</p> <p>Nursing has been in-serviced on Medication. Administration to ensure medications are passed</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  07/22/2013
--	---	--	---

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>without error.</p> <p>Nursing has been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis. Nursing has been in-serviced to include clear, concise documentation when following a patient's plan of care. Re-positioning schedule for clients who need them were developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the</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  07/22/2013
--	---	--	---

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>repositioning. Other clients who have a need to elevate their legs will have a similar chart developed</p> <p>Nurses for residents who have emesis during seizures will monitor vital signs and lung sounds each shift due to risk for aspiration.</p> <p>Residents who are prescribed Keppra and need their medication crushed now have an order that states Keppra may be crushed.</p> <p>Residents who take medications have had their orders reviewed to assure medication is given as prescribed. Nursing has been retrained on giving medication as prescribed.</p> <p>Updated Do Not Crush List is located in each MAR.</p> <p>Nursing will be retrained on completing quarterlies and annuals on a timely basis.</p> <p>Nurses have been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>The Housekeeping Supervisor will complete a daily Checklist and report any maintenance issues to the ED immediately for repair. Housekeeping Supervisor will be trained on the Checklist. The QDDP or designee will</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  07/22/2013
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>complete "Infection Control" retraining with staff including issues that need to be addressed immediately, cleaning up after clients/ encourage clients to clean up after themselves, and how to report issues to cleaning services.</p> <p>The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time of the observation.</p> <p>Staff have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>Dietary employees were trained to use gloves on the dirty side of the kitchen, remove gloves when leaving dirty and going to clean side, using sanitizer, enter clean side and wash hands at hand sink prior to working on the clean side of kitchen. Recreation will utilize wipes for hand washing or assist resident as needed to wash their hands prior to touching equipment that is being used by multiple residents and their hands are soiled. Residents who drool have been assessed by the IDT as to their need for individual interventions to assist with maintaining sanitation around drooling. ADD to observe for procedure of glove use and hand</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  07/22/2013
--	---	--	---

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>sanitizing and hand washing. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff trained P-2 trained that it was his task to report and discard outdated food. Dietary staff trained to chart Dishwasher temperatures on log as required. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be at the temperature stated in the North Willow policy. ED has observed ADD in inputting a work order in building engines to assure she understands and can input order. The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is listed on the form as well as</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  07/22/2013
--	---	--	---

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>instruction that if there is a change or any problem in staff attending, the supervisor will be contacted for direction. Dietary staff have been retrained to follow menu and provide correct menued items. Staff have been retrained to provide prescribed diets including portion sizes.</p> <p>IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Client Advocates will assure process followed when there are cases of allegation of neglect and abuse with follow up with ED/DNS when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director.</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  07/22/2013
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>QIDPs will monitor documentation folders to check that current BSPs are in the classrooms for ready access by CNAs. QIDPs will add monitoring for the appropriate implementation of BSPs and this monitoring will be added to the active treatment sheets.</p> <p>Diet orders, care/risk plans, dining books and CST will be updated following any change to diet orders. Staff will need to sign off on updated information. Program Directors review outings as to effectiveness, safety and client interest both before and after the trip.</p> <p>Fall risk plans for those at high risk for falls are reviewed by the Client Advocates for quality assurance purposes.</p> <p>Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval.</p> <p>THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved.</p> <p>The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time</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  07/22/2013
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>of the observation. Rounds include resident appearance and cleanliness.</p> <p>The PD will review the Environmental Round observations weekly and complete retraining as needed. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director. DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis. Active Treatment audits completed by QMRPs and transfer observations will include proper sling use. DCE/DNS/ADNS will audit care plans for those using slings at least quarterly. Health Information Management completes weekly audits that include nursing quarterlies and annuals, DCE, DNS, and ADNS follow up on deficiencies noted on these reports. Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Nursing to audit 15 minute checks each shift to ensure documentation. QMRP to audit daily to assure 15 minute</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  07/22/2013
--	---	--	---

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
	1. On 7/10/13 at 8:15am, the third floor		documentation. The PD will review the Environmental Round observations weekly and complete retraining as needed. Corrections to be completed by . ADD/Designee observes daily to assure glove use/hand washing procedure is followed properly in the kitchen. QMRPs have been educated to observe their caseload and when issues such as drooling occur, they must implement interventions to assist with the sanitation and dignity issues with it. Program Directors assure QMRP staff assess, develop and implement those interventions. ADD will check dishes to assure dry, assure that P-2 tasks are completed including checking for dates on foods to assure they are not out dated. ADD will input work orders in building engines. ADD checks temperature log for dishwasher. ADD checks cleanliness of cart shelves. Completed by. Out trip forms are reviewed prior to trips being taken to assure correct information is present and staff have been trained on the form and trip procedure. Dining monitors have been retrained to observe and ensure diets are checked by direct care staff and those diets are followed including portion sizes. Completed by 8-21-13.	

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  07/22/2013
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>ice machine had finger prints on the outside of the machine. At 8:15am, the third floor ice machine had a dried brown substance on the outside of the dispensing arm, the bin grill (to prevent the retrieval of ice already dispensed) was missing, and a brown substance was inside the ice bin around the drain portion. From 8:15am until 9:10am, clients on the third floor were observed to approach the ice machine, obtain already dispensed ice from the bin with their fingers, and consume the ice or place it in their cups for use. At 8:15am, the ADD (Assistant Director of Dietary) indicated dietary staff were not responsible for the ice machines on first, second, or third floors for cleaning or maintenance of the ice machines.</p> <p>On 7/10/13 at 10:30am, on 7/11/13 at 12:35pm, and on 7/15/13 at 8am, the cleaning schedules and policy for the first, second, and third floor ice machines were requested from the ADD, the Director of Clinical Education, and the Administrator. No cleaning schedule or policy for ice machines on first, second, or third floors was available for review.</p> <p>2. On 07/10/2013 from 7:45am until 10:15am, observations of the facility kitchen were conducted with the Assistant Director of Dietary (ADD), and the</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  07/22/2013	
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>following was observed:</p> <p>-At 7:45am, the ADD indicated clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148 had food, utensils, or supplies from the dietary department.</p> <p>-At 7:45am, the ADD and Dietary Staff (DS) #48 loaded the pans of food for the third floor on a cart. At 8:00am, the food arrived on the third floor for clients waiting for breakfast. At 8:00am, the ADD and DS #48 indicated the steam table was leaking and did not maintain a correct temperature for the food served.</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  07/22/2013	
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>At 8:35am, DS #48 poured additional water into the steam table bin. The water made a hissing sound and water vapors rose up from the steam table bin beneath the food pans. DS #48 indicated the third floor steam table had been broken over 3 months and pointed to a two (2) quart container underneath which collected the leaking hot water. Water was observed to be leaking from the bottom of the table down into the two quart pan underneath the steam table. The steam table had a metal barrier between the front of the steam table bins and people walking by the steam table. This protective metal covering was missing the connecting screws which held the steam table covering over the food in place. This protective covering would move to expose space between the steam table bins of food and the space in front of the steam table. The steam table had a power plug which had wire exposed and connected power from the outlet to the steam table.</p> <p>-On 7/10/13 at 9:15am, a food cart was observed inside the kitchen being prepared for the lunch meal. The doors of the cart were open showing condiments on a tray inside the food cart, and sixteen of sixteen (16/16) metal cart shelves were dusty and had food debris on them.</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  07/22/2013	
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>-On 7/10/13 at 9:15am, the walk in freezer and refrigerator had torn plastic barrier dividers. The ADD indicated the existing plastic barrier dividers were stained and worn. At 9:15am, the kitchen mop sink had a hose that connected to the nozzle of the sink's water supply and rested the opposite end of the hose into the water reservoir to the sink. No check valve was observed on water supply used from the sink. The ADD indicated she was not aware of the use of check valves to prevent the backflow of dirty water into the clean water supply. The ADD indicated the dietary department used this sink every shift to empty mop water and refill their mop buckets for use.</p> <p>-On 7/10/13 at 9:20am, inside the kitchen reach in freezer were three (3) forty-eight ounces (48oz.) loaves of Cream Cheese which expired on 10/5/2012. The ADD indicated the Cream Cheese was expired and should have been removed from use.</p> <p>-On 7/10/13 at 10:00am, the spice shelves had an opened sixteen ounce (16oz.) bottle of Cinnamon Glaze which indicated "best by 7/2012," and a 16oz. opened bottle of Lemon Glaze which indicated "best by 4/2012." The ADD picked up both items after they were identified then threw them both away into the trash.</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  07/22/2013
--	---	--	---

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>-On 7/10/13 at 10:00am, the dish washer temperature was 142 degrees Fahrenheit for the wash cycle and 170 degrees Fahrenheit for the rinse cycle. The Dish Machine temperature log was requested for review and the ADD indicated she would provide it later. The ADD indicated the wash cycle should be 150 degrees Fahrenheit for the wash cycle and 180 degrees Fahrenheit for the rinse cycle.</p> <p>-On 7/10/13 at 9:30am, the three compartment sink had food debris in the drain which was dried to each of the three bays in the sink. The ADD indicated the three compartment sink was not operational and could not be used. The ADD indicated the sink had been broken over one year.</p> <p>-On 7/10/13 at 9:30am, a liquid was observed between dishes stacked and stored as clean. The Ice Machine scoop was cracked, and stored in a plastic broken sleeve without a covering on the side of the ice machine in the food preparation area. On a cart stored as clean were four of four (4/4) pitchers stored upside down which had water draining from each of the pitchers onto the cart. The cart had food debris on the cart and under the upside down pitchers. Two of five (2/5) Juice coolers were</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  07/22/2013
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>stained and had a dark build up of a brown substance.</p> <p>An interview on 07/11/2013 at 3:00pm with the ADD indicated the wash cycle temperature was 150 degrees Fahrenheit and the rinse cycle was 180 degrees Fahrenheit. The ADD indicated the temperatures were checked and recorded after each meal, then the ADD added numbers to the "Dish Machine Temperature Log" before making a copy of the log. The ADD indicated the dishes are checked for cleanliness before they are put away.</p> <p>An undated policy, titled, "Damaged China and Glassware Surveillance" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...Damaged items are immediately taken out of service...."</p> <p>A 2011 policy, titled, "Dish Machine Use and Care" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...High Temperature machine, Wash - temperature must be maintained at a minimum of 150 F (degrees Fahrenheit) per state regulations during the wash cycle time. Rinse - Temperature must be maintained at a minimum of 180 (degrees) F per gauge...."</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  07/22/2013
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>3. On 7/8/13 at 2:50pm, the facility's reportable incident reports were reviewed for the period from 7/8/2012 through 7/8/2013 and indicated the following regarding client #141's pop money:</p> <p>-A 1/17/13 BDDS report for an incident on 12/31/12 at 4pm, indicated the facility administrative staff were aware of incident on 1/9/13. The report indicated "For additional information regarding the finding regarding the handling of client funds in regard to the purchase of pop/snacks. The information was released by the housekeeping staff that reported the original allegation regarding [CNA (Certified Nursing Assistant) #50 and Client #141] stated that [CNA #51]...told the [HKKP staff] (housekeeping staff) that on December 31 not all pop was being purchased and that sodas were being poured into glasses so that drinks could be shared." The allegation was "not substantiated." The corrective action "Plan to Resolve: [Staff] will be retrained on the use of client funds that includes the use and distribution of pop money before returning to work."</p> <p>-A review of the undated 12/31/12 investigation indicated the facility staff did not immediately report to the administrator an allegation of financial exploitation of client #141's money and</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  07/22/2013
--	---	--	---

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>pop. The undated investigation indicated "...An additional outcome of the (12/31/12 allegation of abuse) investigation raised a concern regarding the handling of client funds in regard to the purchase of pop/snacks." The investigation results indicated "the initial concern was that not all pop was being purchased and that sodas were being poured into glasses so that drinks could be shared. This concern was not founded. What was determined was that on Tuesday's everyone gets pop money gets pop (sic). On the weekends, not all people get pop. [CNA #50] stated that for those people who are not behavioral, he will share the pop by pouring it into cups because it's not fair for some to get pop and not everyone, and it also leads to behaviors (sic). [CNA #50] will be retrained on the need to protect individual resources (client #141's money) and not share one person's items with another." No information was available for review to determine if client #141 was reimbursed for his pop money used for other clients in the facility.</p> <p>On 7/11/13 at 9:50am, an interview was conducted with Administrative (Admin.) Staff #2. Admin Staff #2 indicated the administration should be notified immediately for all allegations. Admin Staff #2 indicated exploitation of client</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  07/22/2013
--	---	--	---

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>#141's pop money was not discovered until a separate incident for an allegation of abuse was being investigated and through interview there was an allegation regarding client #141's pop money. Admin Staff #2 indicated the investigation did not determine a corrective action regarding client #141's pop money.</p> <p>On 7/10/13 at 3:25pm, a review was conducted of client #141's financial client trust funds maintained by the facility with Admin Staff #5 and Admin Staff #6. At 3:25pm, Admin Staff #5 and Admin Staff #6 both indicated client #141 had his personal funds entrusted by the facility. Admin Staff #5 indicated she was unaware of client #141's BDDS report and unaware of the possibility that client #141's pop money was not used for client #141 to obtain a pop and to consume his entire pop. Admin Staff #5 and Admin Staff #6 both stated if client #141 had his pop shared with others without client #141's choice it "would be exploitation" and client #141 should have had his money for pop replaced by the facility.</p> <p>4. Client #127's bedroom was examined during the initial observation period on 7/8/13 from 1:14 P.M. until 2:03 P.M.. Client #127's dresser drawer was observed to be protruding from the</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  07/22/2013
--	---	--	---

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>dresser at a 30 degree angle. The dresser drawer's rails were missing.</p> <p>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 indicated the facility's maintenance department would look at repairing the drawer rails to client #127's dresser.</p> <p>5. The windows in the third floor dining room and in bedrooms #331, 332, 333, 335, and 337 were inspected during the 7/8/13 observation period from 2:59 P.M. until 6:40 P.M.. The windows were noted to be covered in with numerous smudges.</p> <p>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 indicated the facility's maintenance department routinely washes the windows in the facility but was unsure when the windows were last washed.</p> <p>6. The steam table in the third floor dining room was inspected during the 7/9/13 observation period from 5:16 A.M. until 8:55 A.M.. Two clear, two gallon containers were on the bottom shelf. Both containers were noted to be filled with water. Upon examination of the containers with Program Director #3, numerous mosquitoes were in the containers of water.</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  07/22/2013
--	---	--	---

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>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 stated the facility's food service department was in charge of assuring water collected from the steam table was discarded and not allowed to become "stagnant."</p> <p>7. An observation was conducted on the first level of the facility on 7/8/13 from 2:30 P.M. until 6:25 P.M.. At 4:03 P.M., Licensed Practical Nurse (LPN) #2 began administering client #22's prescribed evening medications. LPN #2 tested client #22's Blood Glucose Level (BGL), which tested at 128. LPN #2 did not administer client #22's insulin injection at this time. Review of client #22's Medication Administration Record (MAR) dated 7/1/13 to 7/31/13 indicated: "Novolog 70/30 sliding scale before each meal...subcutaneous per sliding scale before meals 3 times daily...100-150=2 units, 151-200=4 units, 201-250=6 units, over 250=7 units."</p> <p>At 4:13 P.M., LPN #2 tested client #24's BGL. Client #24's BGL tested 86. LPN #2 did not administer client #24's insulin at this time. Client #24 did not eat or drink anything from 4:13 P.M. until her meal time at 5:55 P.M.. Review of client #24's MAR dated 7/1/13 to 7/31/13 indicated: "Novolog 70/30 sliding scale</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  07/22/2013	
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>before each meal...subcutaneous per sliding scale before meals 3 times daily...140-180=4 units, 181-200=6 units, 221-260=8 units, 261-300=10 units, 301-340=14 units, over 340=20 units...Novolog 100 units...13 units twice daily follow sliding scale...Byetta 5 mcg (microgram) dose...5 units daily." At 4:25 P.M.. LPN #2 stated " I am not going to give [client #22] her insulin right now, I will give it to her when the meal cart comes up." LPN #2 then stated "Since [client #24]'s reading is 86 she will not get her Novolog 70/30 insulin but I will give her other insulin when the meal cart comes up." At 5:35 P.M., LPN #2 began administering client #22's insulin. LPN #2 administered 4 units of Novolog 70/30. LPN #2 did not retest client #22's BGL prior to administering client #22's insulin injection. At 5:50 P.M., LPN #2 administered client #24's insulin. LPN #2 administered 13 units of Novolog insulin and 5 units of Byetta insulin. LPN #2 did not retest client #24's BGL before administering client #24's insulin.</p> <p>A request was made to Program Director (PD) #1 for the facility's policy and/or procedure for diabetic protocols on 7/10/13 at 11:00 A.M.. No policy and/or procedure was submitted for review. A second request for a diabetic policy and/or protocol was made to the Assistant</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  07/22/2013
--	---	--	---

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>Director of Nursing (ADON) on 7/12/13 at 11:00 A.M.. The ADON stated "I'm not sure if there is one, I will have to check and I will make you a copy if there is." No policy and/or procedure was submitted for review.</p> <p>An interview with the Director of Nursing (DON) the ADON and Registered Nurse (RN) #7 was conducted on 7/12/13 at 1:30 P.M.. When asked if the facility had a policy and/or procedure for diabetic protocols, the DON stated "We do not have a written policy and/or procedure." When asked if a client's BGL is tested, within what time frame should their sliding scale insulin be administered and when should the client eat, the RN stated "Within 30 minutes." When asked if a client's insulin should be administered an hour and 30 minutes after the BGL reading, the RN stated "No that is too long of a time." When asked if clients #22 and #24's BGL levels should have been retested prior to eating their evening meal, the RN stated "Yes." The DON asked "Did [client #24] receive a snack when her BGL read at 86?" The DON was informed she had not.</p> <p>8. Observations were conducted on the third floor, North wing on 7/10/13 from 3:15 PM through 4:15 PM. Client #106's personal/bedroom restroom's toilet seat</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  07/22/2013
--	---	--	---

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>was not attached to the toilet and was hanging off the right side of the toilet. Clients #13, #110 and #111's bedroom closet had a gray to black film like substance in the front left corner of the ceiling of the closet. The area was circular and was 3 inches in diameter with a yellow colored ring surrounding the gray/black film. Clients #102 and #103's bedroom ceiling vent cover was hanging from the ceiling and was attached to the ceiling with one of the two screws.</p> <p>Director of Maintenance (DM) #1 was interviewed on 7/10/13 at 4:26 PM. DM #1 indicated client #106's toilet seat should be attached to the toilet base. DM #1 indicated clients #13, #110 and #111's closet had mold growing in the ceiling corner. DM #1 indicated clients #102 and #103's ceiling vent should be attached to the ceiling and not hang down.</p> <p>9. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure safeguards were implemented to prevent client #76 from further injury due to falls, to monitor/supervise client #76 after a fall resulting in a head injury and to provide client #76 with timely medical services to rule out potential traumatic head injury due to a fall which resulted in</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  07/22/2013
--	---	--	---

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>an Immediate Jeopardy. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure client #149 was monitored/supervised to prevent client to client abuse resulting in a head injury requiring immediate medical attention of 911. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's administrator recognized an allegation of verbal abuse involving client #141, reported the abuse to state officials timely, suspended staff to protect clients, and/or failed to initiate an investigation of the staff's interactions with clients to ensure clients were not subjected to abuse. The governing body failed to exercise general policy and operating direction over the facility to ensure client #149 was supervised/monitored due to illness and free from client to client abuse resulting in a traumatic head injury requiring 911 assistance. The governing body failed to exercise general policy and operating direction over the facility to report injuries of unknown source to the administrator timely for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. The governing body failed to exercise general policy and operating direction over the facility to prevent exploitation of client #141 in regard to the</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  07/22/2013	
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>use of the client's pop money. The governing body failed to exercise general policy and operating direction over the facility to prevent neglect and/or abuse of client #37 in regard to a choking incident, and in regard to falls involving client #132 which resulted in injuries/trips to the emergency room. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to client #15, #16 and #55's fractures. Please W149.</p> <p>10. The governing body failed to exercise general policy and operating direction over the facility to ensure the clients participated in activities in the community on a regular and/or ongoing basis in regard to clients #1, #2, #3, #4, #5, #8 and #9. Please see W136.</p> <p>11. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse, neglect and/or injuries of unknown source immediately reported to the administrator and/or to state officials per state law for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. Please see W153.</p> <p>12. The governing body failed to exercise general policy and operating direction</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  07/22/2013	
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>over the facility to ensure the facility conducted thorough investigations in regard to injuries of unknown source/fractures for clients #15, #16 and #55. Please see W154.</p> <p>13. The governing body failed to exercise general policy and operating direction over the facility to ensure a professional staff person was immediately suspended in regard to an allegation of verbal abuse for client #141. Please see W155.</p> <p>14. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services met the nursing needs of clients which provided client #76 with timely medical services to rule out potential head injury due to fall, monitored/supervised client #76 after a fall resulting in a head injury and instructed the direct care staff in supervising/monitoring and providing client #76 health care in regard to falls with head injury. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services assessed/monitored client #86 due to skin ulcerations and ensured the staff followed the client's plan of care and documented the client's information, supervised and monitored client #149 to prevent injury</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  07/22/2013
--	---	--	---

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>resulting in a head injury due to client to client abuse, repositioned client #9 every 2 hours and documented the position she was placed in on the positioning schedule. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services administered clients #1 and #23's medications as ordered, and to obtain follow-up medical appointments for clients #1 and #3. Please see W331.</p> <p>15. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services conducted quarterly nursing assessments of clients' health status and medical needs for clients #2 and #4. Please see W336.</p> <p>16. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services ensured all medications were administered without error for 3 of 40 doses administered for clients #24, #71 and #72. Please W369.</p> <p>17. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services locked all medications until ready for administration which effected 5 of 15 sampled clients (clients #11, #12,</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  07/22/2013
--	---	--	---

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>#13, #14, and #15) and 50 of 133 additional clients (clients #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) who lived on the third floor of the facility. Please see W382.</p> <p>3.1-13(a) 3.1-13(r) 3.1-13(s)</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  07/22/2013	
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			
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 additional client (#76). The facility failed to implement written policy and procedures: to prevent neglect of client #76 in regards to a fall which resulted in a head injury, to monitor/supervise client #76 in regard to the client's history of falls, to implement safeguards to prevent client #76 from further injury due to reoccurring falls and to ensure nursing services obtained timely medical services for client #76 to rule out potential traumatic head injury due to a fall which resulted in an Immediate Jeopardy.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 7/11/13 at 5:15 PM. The Immediate Jeopardy began on 6/28/13 when the facility failed to implement safeguards to prevent client #76 from further and/or future injury due to falls and failed to provide client #76 with timely medical services after a fall on 7/11/13. The Executive Director and the Director of Nursing Services were notified of the Immediate Jeopardy on 7/11/13 at 6:03 PM regarding the failure</p>	W000122	<p>W122 I QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid. For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other, injury are specified.. Nursing staff will be retrained on</p>	08/21/2013			

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  07/22/2013	
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>of the facility's system to prevent further and/or future injury due to falls.</p> <p>The facility submitted a plan of action to remove the immediate jeopardy on 7/11/13. The 7/11/13 Plan to Abate indicated,</p> <p>"1. Staff have been retrained on identification and reporting of abuse and neglect beginning on 7/11/13 and ongoing.</p> <p>2. [Client #76] (sic) room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed 7/11/13. A 1:1 staff is assigned 24/7 beginning 7/11/13. 1:1 will be contained pending [client #76] being evaluated by physical therapy with recommendations fully implemented and trained with staff. 1:1 plan has been implemented 7/11/13. Training completed with assigned CNA (Certified Nurses Aide) 7/11/13 and is ongoing. Nursing care plan for falls is in place.</p> <p>3. Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neurological checklist to be completed per guidelines and completed 7/11/13. Nurse for [client #76]</p>		<p>the need to notify the ED or DNS of any significant changes of status</p> <p>The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.</p> <p>Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</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  07/22/2013
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>during fall 7/11/13 has been trained prior to her next scheduled shift. Nursing staff has been trained beginning on 7/11/13 and ongoing.</p> <p>4. A fall assessment has been implemented to be completed after any fall by CNA/Designee, training begun with CNA staff 7/11/13 and ongoing.</p> <p>5. Nursing has been trained to notify ED (Executive Director) and DNS (Director of Nursing Services)/ANDS (Assistant Director of Nursing Services) immediately following fall with assessment with training beginning 7/11/13 and ongoing. Nurses trained including nurse for [client #76] during fall 7/11/13 prior to her next scheduled shift and nurse training starting 7/11/13 and ongoing.</p> <p>6. Nurse for [client #76] during fall 7/11/13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well beginning 7/11/13 and ongoing.</p> <p>7. The fall assessment will be reviewed by the IDT (Interdisciplinary Team) to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs</p>		<p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan.</p> <p>QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility and (b) requiring additional evaluation (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>Client #132's IDT to met and review her fall care/risk plan and her BSP (for relationship between behavioral incident and fall) for</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  07/22/2013
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>(Qualified Mental Retardation Professionals) will be trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan beginning 7/12/13 and ongoing."</p> <p>Observations were conducted on the second floor west hall of the facility on 7/15/13 from 2:10 PM through 3:15 PM. CNA #1 completed 15 minute status checks of client #76 and remained within arms reach of client #76 until relieved from her shift at 2:30 PM. At 2:30 PM CNA #3 relieved CNA #2 from being client #76's one to one staff. CNA #3 remained in arms reach of client #76 and completed 15 minute status checks. CNAs #2 and #3 documented the 15 minute status checks on the 15 minute check interval sheet located in client #76's bedroom.</p> <p>CNA #15 was interviewed on 7/16/13 at 2:15 PM. CNA #15 indicated she had been retrained/in serviced on 7/11/13 regarding identification and reporting of abuse and neglect, fall assessment protocol and client #76's one to one staffing protocol. CNA #15 indicated client #76's room had been changed to a classroom directly across the hallway from the unit programming room. CNA #15 indicated client #76 had not had any additional falls since 7/11/13.</p>		<p>compatibility with her most recent evaluations/recommendations. Recommendations on her current care plan will be reviewed and any that are outdated (was there a PT eval re: does she need strengthening program?) will be deleted/struck out. Any updates/revisions made will be added to her CST and nursing and CNA staff will be retrained on those revisions. Housekeeping staff will be inserviced to refrain from mopping floors in rooms where clients are present. Inservice training will include contacting the QIDP or PD of the floor for assistance if there is a need to mop immediately. Client #132's IDT will meet to determine a nail care regimen for her and if a formal goal is needed to assure completion. For any clients for whom there have been injuries associated with nail care (scratches/unknown injuries) in the past 6 months, their IDTs will meet and develop similar regimens/recommendations. Client #132's IDT will meet to discuss falls occurring at night and develop interventions that can provide additional protections for her. Defining remote supervision will be included in the development of those plans.</p> <p>For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated. With</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  07/22/2013
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>CNA #16 was interviewed on 7/16/13 at 2:20 PM. CNA #16 indicated she had been retrained/in-serviced on 7/11/13 regarding identification and reporting of abuse and neglect, fall assessment protocol and client #76's one to one staffing protocol. CNA #16 indicated client #76's room had been changed to a classroom directly across the hallway from the unit programming room. CNA #16 indicated client #76 had not had any additional falls since 7/11/13.</p> <p>CNA #1 was interviewed on 7/16/13 at 2:23 PM. CNA #1 indicated she had been retrained/in-serviced on 7/11/13 regarding identification and reporting of abuse and neglect, fall assessment protocol and client #76's one to one staffing protocol. CNA #1 indicated client #76's room had been changed to a classroom directly across the hallway from the unit programming room. CNA #1 indicated client #76 had not had any additional falls since 7/11/13.</p> <p>CNA #17 was interviewed on 7/16/13 at 2:25 PM. CNA #17 indicated she was client #76's one to one staff for the day (7/16/13). CNA #17 indicated she remained within arms reach of client #76 and ensured client #76 did not fall. CNA #17 indicated 15 minute status checks</p>		<p>regard to resident 141 staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. (cannot ever use Soc. Sec. money. Person has to be able to give informed consent to buy/give gifts with earned money.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Staff for resident 76 have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>For the individual who knocked over #149's wheelchair, antecedents and reactive interventions for AWOL in her BSP will be reviewed. Staff who work with her will be retrained on the BSP.</p> <p>Reinstitute the flow chart: BIR/Fall Assessment -resident 76s Nurse has been trained on</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  07/22/2013	
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>were completed and documented for client #76. CNA #17 indicated she had been retrained/in-serviced on 7/11/13 regarding identification and reporting of abuse and neglect, fall assessment protocol and client #76's one to one staffing protocol. CNA #17 indicated client #76 had not had any additional falls since 7/11/13.</p> <p>CNA #18 was interviewed on 7/16/13 at 2:35 PM. CNA #18 indicated she was client #76's one to one staff for the evening shift. CNA #18 indicated she remained within arms reach of client #76 and ensured client #76 did not fall. CNA #18 indicated 15 minute status checks were completed and documented for client #76. CNA #18 indicated she had been retrained/in-serviced on 7/11/13 regarding identification and reporting of abuse and neglect, fall assessment protocol and client #76's one to one staffing protocol. CNA #18 indicated client #76 had not had any additional falls since 7/11/13.</p> <p>Client #76's 15 minute interval check binder/folder was reviewed on 7/16/13 at 2:25 PM. Client #76's 15 minute interval checks documentation had been completed from 7/11/13 through the time of the observation.</p>		<p>flow chart to determine if need to call ED - BIR box for follow-up. For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated. With regard to resident 141 staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. (cannot ever use Soc. Sec. money. Person has to be able to give informed consent to buy/give gifts with earned money. Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury. For residents 1, 2, 3, 4, and 5 QMRP and Program Director who serves them has been retrained on the Community Integration Policy for North Willow. This policy was approved in POCs for surveys ID: CRT311 and ID: CTR312 respectively.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Administrative, supervisory and nursing staff to be retrained on the policy with any changes/revisions highlighted. CNA and other support staff will be retrained on the falls</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 07/22/2013
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>LPN #1 was interviewed on 7/16/13 at 2:45 PM. LPN #1 indicated she had been retrained regarding identification and reporting of abuse and neglect, fall assessment protocol revisions and the facility's notification and emergency services protocols.</p> <p>PD (Program Director) #2 was interviewed on 7/16/13 at 3:00 PM. PD #2 indicated she had assisted with retraining CNAs and QMRPs regarding identification and reporting of abuse and neglect and fall assessment protocol revisions.</p> <p>The facility's in-service forms binder/folder was reviewed on 7/16/13 at 4:40 PM. The in-service forms binder/folder indicated the facility had completed retraining CNAs, Nurses and QMRPs regarding the following:</p> <ul style="list-style-type: none"> <li>-Identification and reporting of abuse and neglect.</li> <li>-One to one staffing protocol regarding client #76.</li> <li>-Fall assessment protocol with revised neurological checklist/guidelines.</li> <li>-In-service record regarding Nurse #1's retraining for notification of</li> </ul>		<p>procedure including where fall risk information is maintained and what follow-up expectations are in place.</p> <p>For those individuals with a history of multiple falls or falls with significant injury (requiring more than in-house 1st aid), the IDTs will meet to review existing care (risk) plans to assure they are current, reflect most recent PT/professional recommendations and clarify expectations during the period following the fall and prior to the meeting of the IDT.</p> <p>Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. Revised fall procedure to be educated with staff.</p> <p>QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>Staff have been retrained on identification and reporting of abuse and neglect.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nursing staff have been trained.</p> <p>A fall assessment has been implemented to be completed</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  07/22/2013
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>administrative staff and contacting emergency services following a fall with head injury.</p> <p>DCE #1 (Director of Clinical Education) was interviewed on 7/16/13 at 4:50 PM. DCE #1 indicated she had assisted retraining the facility CNAs and Nurses regarding identification and reporting of abuse and neglect, one to one staffing protocol regarding client #76, fall assessment protocol with revised neurological checklist/guidelines and notification of administrative staff and contacting emergency services following a fall with head injury.</p> <p>The Executive Director and the Director of Nursing Services were notified of the removal of Immediate Jeopardy on 7/16/13 at 5:05 PM. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at the Condition of Participation: Client Protections as the facility needed to demonstrate ongoing implementation of the added safeguards to prevent further injury to client #76.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 8 of 15 sampled clients (#1, #2, #3, #4, #5, #8, #9 and #15) and</p>		<p>after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nursing staff have been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion.</p> <p>The fall assessment will be used by the IDT to assist in development or revision of the fall prevention/safe ambulation plan when needed. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. Administrative, supervisory and nursing staff are to be retrained on the reviewed/ revised abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse. Allegations of staff misconduct related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures are in place, that the Executive Director or designee has been</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  07/22/2013	
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>for 14 additional clients (#16, #20, #27, #37, #55, #71, #73, #76, #94, #118, #132, #135, #141 and #149). The facility failed to ensure all clients participated in activities in the community, reported allegations of abuse, neglect and/or injuries of unknown source timely, conducted thorough investigations, and removed a staff person from client contact once an allegation was made. The facility also failed to implement its policy and procedures to prevent neglect and/or abuse of clients who lived in the facility.</p> <p>Findings include:</p> <p>1. The facility neglected to implement its policy and procedures to ensure safeguards were implemented to prevent client #76 from further injury due to falls, to monitor/supervise client #76 after a fall resulting in a head injury and to provide client #76 with timely medical services to rule out potential traumatic head injury due to a fall which resulted in an Immediate Jeopardy.</p> <p>The facility failed to implement its policy and procedures to ensure client #149 was monitored/supervised to prevent client to client abuse resulting in a head injury requiring immediate medical attention of 911. The facility failed to implement its written policy and procedures to prevent</p>		<p>notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>Nurses have been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>For all clients with AWOL and/or physical assault in their plans, the BSPs will be reviewed for appropriateness. CST will be reviewed to monitor that current information/interventions are included.</p> <p>Nurses trained on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>For all clients with identified choking risks, the PD or Q will review the outing form for completeness and accuracy in diet orders, staffing levels, etc. The outing form is taken by staff for reference during the activity. If there are additional dining risks (i.e.: individual compliance), that information will also be noted on the outing form. Staff have been trained on the Heimlich and training to competency will be completed by staff annually.</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  07/22/2013	
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			
	neglect, abuse and/or exploitation of clients. The facility's administrator failed to recognize an allegation of verbal abuse involving client #141 was reported to state officials timely, to ensure staff was suspended to protect clients, and/or failed to initiate an investigation of the staff's interactions with clients to ensure clients were not subjected to abuse. The facility failed to implement its policy and procedures to ensure client #149 was supervised/monitored due to illness and free from client to client abuse resulting in a traumatic head injury requiring 911 assistance. The facility failed to implement its written policy and procedures to report injuries of unknown source to the administrator timely for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. The facility failed to implement its policy and procedures to prevent exploitation of client #141 in regard to the use of the client's pop money. The facility failed to implement its policy and procedures to prevent neglect and/or abuse of client #37 in regard to a choking incident, and in regard to falls involving client #132 which resulted in injuries/trips to the emergency room. The facility facility to conduct thorough investigations in regard to client #15, #16 and #55's fractures. Please see W149.		Monitoring for implementation of behavior support plans will be added to the active treatment observations done by the QIDP. The fall care/risk plans for any individual with a history of falls at night (multiple falls or falls with injury) will be reviewed by the IDTs for inclusion of interventions specific to this need. Nursing and CNA staff will be retrained on any revisions, and revisions will be updated on the CST. Clients with a fall risk plan will have their shoes assessed for appropriateness and fit. The use of gripper socks will be encouraged and staff will be inserviced on the need to complete a BIR for refusal to follow fall prevention protocols. As part of active treatment training, CNAs will be inserviced on the need to keep people awake in classrooms and common areas and methods to help prevent people from sleeping in chairs. An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of documentation, staff interviews (from all 3 shifts if the fall/injury				

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  07/22/2013	
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>2. The facility failed to ensure the clients participated in activities in the community on a regular and/or ongoing basis in regard to clients #1, #2, #3, #5, #4, #8 and #9. Please see W136.</p> <p>3. The facility failed to report all allegations of abuse, neglect and/or injuries of unknown source were immediately reported to the administrator and/or to state officials per state law for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. Please see W153.</p> <p>4. The facility failed to conduct thorough investigations in regard to fractures for clients #15, #16 and #55. Please see W154.</p> <p>5. The facility failed to immediately suspend a professional staff in regard to an allegation of verbal abuse for client #141. Please see W155.</p>		<p>was not observed), and a conclusion including what is being done to help prevent reoccurrence. Staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. (cannot ever use Soc. Sec. money. Person has to be able to give informed consent to buy/give gifts with earned money. QMRP and Program Directors have been retrained on the Community Integration Policy for North Willow.</p> <p>IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Client Advocates will assure process followed when there are cases of allegation of neglect and</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  07/22/2013
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>abuse with follow up with ED/DNS when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director.</p> <p>QIDPs will monitor documentation folders to check that current BSPs are in the classrooms for ready access by CNAs. QIDPs will add monitoring for the appropriate implementation of BSPs and this monitoring will be added to the active treatment sheets</p> <p>Fall risk plans for those at high risk for falls are reviewed by the Client Advocates for quality assurance purposes.</p> <p>Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval.</p> <p>THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved. The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time of the observation. Rounds include resident appearance and</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  07/22/2013
--	---	--	---

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>cleanliness.</p> <p>The PD will review the Environmental Round observations weekly and complete retraining as needed. Corrections to be completed by August 21, 2013. Program Directors must review outings to assure they follow the policy for amount, variety and in cases when participation does not occur due to illness, lack of desire, etc., an IDT is completed for the resident. Additionally, if there is more than one refusal of an outing, a training or desensitization program is developed to assist the resident in participating more in the community. Also, Quality Assurance in addition to requesting outing information will require Program Directors to provide a copy of the IDT when a resident does not attend their outing(s) for that month. Completed by 8-21-13.</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  07/22/2013	
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			
W000136	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on record review and interview, the facility failed to provide frequent opportunities for out of home social, religious and group activities for 7 of 15 sampled clients (clients #1, #2, #3, #4, #5, #8 and 9).</p> <p>Findings include:</p> <p>1. A review of the facility's "Community Outings" record dated 7/1/12 to 6/30/13 for the first level was conducted at the facility's administrative office on 7/10/13 at 12:10 P.M.. Review of the record did not indicate clients #1, #2, #3, #4 and #5 participated in frequent social, religious or community group activities.</p> <p>July 2012 community outings:</p> <p>[Client #1]: 7/11-Walk</p> <p>[Client #2]: No outings</p> <p>[Client #3]: 7/30-Walk</p> <p>[Client #4]: 7/30-Walk</p>	W000136	<p>W136</p> <p>I For residents 1, 2, 3, 4, and 5 QMRP and Program Director who serves them has been retrained on the Community Integration Policy for North Willow. This policy was approved in POCs for surveys ID: CRT311 and ID: CTR312 respectively.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III QMRP and Program Directors have been retrained on the Community Integration Policy for North Willow.</p> <p>IV Program Directors must review outings to assure they follow the policy for amount, variety and in cases when participation does not occur due to illness, lack of desire, etc., an IDT is completed for the resident. Additionally, if there is more than one refusal of an outing, a training or desensitization program is developed to assist the resident in participating more in the community. Also, Quality Assurance in addition to requesting outing information will require Program Directors to</p>	08/21/2013			

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  07/22/2013
--	---	--	---

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>[Client #5]: 7/1-Church, 7/18-Very Special Arts, 7/30-Walk</p> <p>August 2012 Community Outings:</p> <p>[Client #1]: 8/29-Walk</p> <p>[Client #2]: 8/30-Walk</p> <p>[Client #3]: 8/29-Walk</p> <p>[Client #4]: 8/28-Park</p> <p>[Client #5]: 8/5-Church, 8/13-Walk, 8/17-Festivals, 8/20-Special Olympics, 8/22-Very Special Arts</p> <p>September 2012 Community Outings:</p> <p>[Client #1]: 9/13-Restaurant/Dining</p> <p>[Client #2]: 9/12-Park</p> <p>[Client #3]: 9/12-Park</p> <p>[Client #4]: 9/20-Other, 9/28-Shopping</p> <p>[Client #5]: 9/5-Other, 9/21-Restaurant/Dining</p> <p>January 2013 Community Outings:</p> <p>[Client #1]: 1/7-Other, 1/30-Other</p>		<p>provide a copy of the IDT when a resident does not attend their outing(s) for that month. Completed by 8-21-13.</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  07/22/2013
--	---	--	---

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>[Client #2]: 1/28-Restaurant, 1/30-Other</p> <p>[Client #3]: 1/3-Medical, 1/8-Shopping, 1/30-Other</p> <p>[Client #4]: 1/17-Restaurant, 1/24-Movies, 1/28-Restaurant</p> <p>[Client #5]: 1/9-Restaurant, 1/10-Restaurant, 1/13-Church, 1/27-Church,</p> <p>February 2013 Community Outings:</p> <p>[Client #1]: 2/5-Other, 2/21-Restaurant</p> <p>[Client #2]: 2/5-Other</p> <p>[Client #3]: 2/25-Other</p> <p>[Client #4]: 2/5-Other, 2/13-Restaurant,</p> <p>March 2013 Community Outings:</p> <p>[Client #1]: 3/28-Other</p> <p>[Client #2]: 3/11-Other</p> <p>[Client #3] 3/28-Other</p> <p>[Client #4]: 3/26-Other</p> <p>[Client #5]: 3/10-Church, 3/12-Shopping,</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  07/22/2013	
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>3/24-Church</p> <p>April 2013 Community Outings:</p> <p>[Client #1]: 4/18-Walk</p> <p>[Client #2]: 4/15-Restaurant</p> <p>[Client #3]: 4/25-Other</p> <p>[Client #4]: 4/5-Shopping, 4/8-Walk</p> <p>May 2013 Community Outings:</p> <p>[Client #1]: 5/1-Walk, 5/20-Shopping</p> <p>[Client #2]: 5/29-Other</p> <p>[Client #3]: 5/14-Zoo</p> <p>[Client #4]: 5/29-Other</p> <p>June 2013 Community Outings:</p> <p>[Client #1]: 6/20-Walk,</p> <p>[Client #2] 6/3-Restaurant, 6/19-Walk, 6/26-Walk</p> <p>[Client #3]: 6/13-Park,</p> <p>[Client #4]: 6/17-Walk,</p> <p>An interview with Qualified Intellectual</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  07/22/2013	
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>Disabilities Professional (QIDP) #3 and Program Director (PD) #1 was conducted on 7/12/13 at 12:40 P.M.. When asked how often the clients get out into the community, PD #1 stated "It depends on each client, but we try to get them out often."</p> <p>2. Client #8's record was reviewed on 7/12/13 at 2 PM. Client #8's Out Trip Forms for 2013 indicated client #8 went on the following outings:          __01/7/13 to a general discount store for 2 hours.          __2/13/13 on an outing to identify community traffic signs. Length of outing is not documented.          __3/21/13 on an outing for 30 minutes to identify community signs.          __06/07/13 to a department store for 1 hour.          Client #8's record did not indicate client #8 went on any community outings in April and May 2013.</p> <p>Client #9's record was reviewed on 7/12/13 at 3 PM. Client #9's Out Trip Forms for 2013 indicated client #9 went on the following outings:          __01/8/13 to a general discount store for 2 hours.          __2/13/13 on an outing to identify community traffic signs. Length of outing is not documented.</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  07/22/2013
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>__3/21/13 on an outing for 30 minutes to identify community signs.</p> <p>__5/10/13 on a community walk for 20 minutes.</p> <p>__6/19/13 on an outing for 1 hour to get ice cream.</p> <p>Client #9's record did not indicate client #9 went on any community outings in April 2013.</p> <p>Telephone interview with Program Director (PD) #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM indicated all clients were to go on a community outing once a month. The PD and QIDP indicated client #9's vision was impaired and the client was not able to see clearly. When asked how client #9 would benefit from a community outing to identify traffic/community signs due to her inability to see, the QIDP stated the clients were taken to the park "and they walked around a bit."</p> <p>3.1-3(m)</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  07/22/2013	
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			
W000149	<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.</p> <p>Based on observation, record review and interview for 2 additional clients (#76 and #149), the facility neglected to implement its policy and procedures to ensure safeguards were implemented to prevent client #76 from further injury due to falls, to ensure client #76 was monitored/supervised after a fall resulting in a head injury and to ensure client #76 was provided with timely medical services to rule out potential traumatic head injury due to a fall.</p> <p>Based on observation, interview and record review for 1 of 15 sampled clients (#15) and for 14 additional clients (#16, #20, #27, #37, #55, #71, #73, #76, #94, #118, #132, #135, #141 and #149), the facility failed to implement its written policy and procedures to prevent neglect, abuse and/or exploitation of clients. The facility's administrator failed to recognize an allegation of verbal abuse involving client #141 was reported to state officials timely, to ensure staff was suspended to protect clients, and/or neglected to initiate an investigation of the staff's interactions with clients to ensure clients were not subjected to abuse. The facility neglected</p>	W000149	<p>W149 I QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall.</p> <p>QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other, injury are specified..</p>	08/21/2013			

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  07/22/2013	
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>to implement its policy and procedures to ensure client #149 was supervised/monitored due to illness and free from client to client abuse resulting in a traumatic head injury requiring 911 assistance. The facility neglected to implement its written policy and procedures to report injuries of unknown source to the administrator timely for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. The facility neglected to implement its policy and procedures to prevent exploitation of client #141 in regard to the use of the client's pop money. The facility neglected to implement its policy and procedures to prevent neglect and/or abuse of client #37 in regard to a choking incident, and in regard to falls involving client #132 which resulted in injuries/trips to the emergency room. The facility neglected to conduct thorough investigations in regard to client #15, #16 and #55's fractures.</p> <p>Findings include:</p> <p>1. A facility BDDS (Bureau of Developmental Disabilities Services) report of 7/12/13 at 9:56 AM reviewed on 7/12/13 at 1 PM indicated on 7/11/13 at 7:15 AM "[Client #76] fell in the bathroom, receiving a 'v' shaped laceration (3 cm x 3 cm) (centimeter) to</p>		<p>Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status</p> <p>The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.</p> <p>Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</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  07/22/2013	
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>her forehead and a cut to the bridge of her nose. Steri strips were applied in house. Vitals were taken with her blood pressure reading 195/133, temp 96.2 and O2 saturation 98%. Her physician was contacted and did not order her to be sent out. Due to concerns related to a prior fall with injury to the back of her head (previously reported), [client #76] was sent to [name of hospital] ER. [Client #76] returned yesterday evening with new diagnosis of closed head injury, and facial laceration."</p> <p>Review of the facility falls reports from April 2013 through July 2013 on 7/9/13 at 9 AM indicated:          ___ On 4/18/13 client #76 walked away from her walker to throw some trash away and fell to her buttocks. No injury was reported.          ___ On 6/6/13 at 7:20 PM client #76 tripped on a chair and fell, hitting her head on another chair as she went down. The report indicated client #76 obtained a small laceration to the bridge of her nose and a bump on her forehead.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 7:20 AM and 7:45 AM. Client #76 was lying in her bed in her bedroom when LPN (Licensed Practical Nurse) #6 entered the client's bedroom to</p>		<p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility and (b) requiring additional evaluation (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>Staff for resident 76 have been retrained to assist in cleaning up</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  07/22/2013	
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>give client #76 her AM medications. Client #76 made verbal sounds. Client #76 had a hospital bracelet on her right wrist. LPN #6 was asked why client #76 had a hospital bracelet on and LPN #6 indicated the client was taken to the hospital on 7/8/13 to have staples removed from the back of her head due to an injury from a fall on 6/28/13. Client #76 had a quarter size hematoma on the back of her head. Client #76 turned her head toward the door, pointed toward the entrance door of her room and stated, "I fell." Client #76's abdomen was partially exposed with 2 greenish yellow bruises visible on her right lower quadrant of her abdomen, one the size of a quarter and the other a nickel. LPN #6 stated "I didn't know she had those."</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 9:45 AM through 10:00 AM. At 9:45 AM client #76 was seated in a chair facing the North window of her bedroom. There were no facility staff in client #76's bedroom at 9:45 AM. Client #76 had a half-dollar, red, raised area located to left/center of her forehead above her left eyebrow. Client #76's raised area was covered with two steri strips which were saturated with dark red to black fluid. Client #76's forehead and hairline had dried dark red to black fluid.</p>		<p>a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood.</p> <p>QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>For the individual who knocked over #149's wheelchair, antecedents and reactive interventions for AWOL in her BSP will be reviewed. Staff who work with her will be retrained on the BSP.</p> <p>Reinstitute the flow chart: BIR/Fall Assessment -resident 76s Nurse has been trained on flow chart to determine if need to call ED - BIR box for follow-up.</p> <p>Client #37's IDT did meet to review her dining plans and risks. PD or Q will review outing form for completeness and accuracy, staffing levels, etc. The outing form is taken by staff for reference during the activity. Recreation staff will receive training specific to Client #37's diet. Staff who working directly with client #37 have been trained on the Heimlich and training to competency.</p> <p>Client #132's IDT to met and review her fall care/risk plan and her BSP (for relationship between</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  07/22/2013	
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>Client #76's index, middle, ring finger and thumb nails had dried dark red to black fluid under the fingernails. Client #76's left temple area was swollen, dark red to black in color. The bridge of client #76's nose, between her eyes, was swollen and colored dark red to black. At 9:50 AM CNA (Certified Nurse Aide) #1 entered client #76's bedroom. CNA #1 directed client #76 to use her walker and come to the unit program room. CNA #1 and client #76 exited the bedroom and the client walked to the unit program room without physical assistance or physical prompts from CNA #1. Client #76 then returned to her bedroom. Client #76's forehead was wiped with a wet tissue. Client #76's steri strips were not changed or cleaned.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 10:50 AM through 12:05 PM. At 10:50 AM client #76 was seated in a chair in the classroom. The client had a large hematoma (swollen area) the size of a quarter above her left brow near her nose. The hematoma had two steri-strips that were saturated with dried blood with a small amount of fresh blood oozing around the steri-strips. Client #76 had blood smeared on her forehead, across the bridge of her nose and on her fingers and one steri-strip across the bridge of her</p>		<p>behavioral incident and fall) for compatibility with her most recent evaluations/recommendations. Recommendations on her current care plan will be reviewed and any that are outdated. Any updates/revisions made will be added to her CST and nursing and CNA staff will be retrained on those revisions. Housekeeping staff will be inserviced to refrain from mopping floors in rooms where clients are present. Inservice training will include contacting the QIDP or PD of the floor for assistance if there is a need to mop immediately. Client #132's IDT will meet to determine a nail care regimen for her and if a formal goal is needed to assure completion. For any clients for whom there have been injuries associated with nail care (scratches/unknown injuries) in the past 6 months, their IDTs will meet and develop similar regimens/recommendations. Client #132's IDT will meet to discuss falls occurring at night and develop interventions that can provide additional protections for her. Defining remote supervision will be included in the development of those plans.</p> <p>For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated. With regard to resident 141staff will be retrained that they cannot use other people's money for any</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  07/22/2013
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	
	nose as well as abrasions above and around her left eye with noted bruising. CNA #1 was sitting at the table nearby client #76 and was asked what was on client #76's face. CNA #1 stated "That's blood where she fell and she keeps scratching at herself." CNA #1 put on gloves and attempted to wipe client #76's forehead with a disposable hand towelette. Client #76 pushed CNA #1 away while making crying sounds. CNA #1 stated, "Oh, she always does that when I touch her face. She don't like anybody touching her." CNA #1 was asked if client #76 had been offered an ice pack. CNA #1 stated, "No, no one has said anything about her using an icepack and I haven't seen her with one." The CNA indicated she had not been given any instructions from the LPN to offer client #76 an icepack. At 10:55 AM client #76 got up from her chair and walked to the bathroom in the activity room. Client #76 walked with an unsteady gait using a rolling walker. Client #76 set her walker outside of the bathroom and proceeded to go into the bathroom by herself. CNA #1 stated, "See, she always does that. We can't get her to use her walker and then she falls." CNA #1 opened the bathroom door to assist client #76. Client #76 had urinated on her clothing while in the bathroom and walked to her bedroom, using her walker and unassisted by the		reason without OK from PD/business office. (cannot ever use Soc. Sec. money. Person has to be able to give informed consent to buy/give gifts with earned money. Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.  II All residents of North Willow have the potential to be harmed by the deficient practice.  III Administrative, supervisory and nursing staff to be retrained on the policy with any changes/revisions highlighted. CNA and other support staff will be retrained on the falls procedure including where fall risk information is maintained and what follow-up expectations are in place. For those individuals with a history of multiple falls or falls with significant injury (requiring more than in-house 1st aid), the IDTs will meet to review existing care (risk) plans to assure they are current, reflect most recent PT/professional recommendations and clarify expectations during the period following the fall and prior to the meeting of the IDT. Fall procedure will address		

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  07/22/2013
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>staff. CNA #1 followed client #76 to her bedroom and assisted client #76 to change her clothes. At 11:05 AM, after changing clothes, client #76 walked back to the classroom, again unassisted by the staff and sat in one of the chairs near the window. CNA #1 was asked if client #76 was able to communicate and to express when she was in pain. CNA #1 stated "For the most part, she can let you know when she's hurting, but not always." Client #76 was asked if she hurt or was in pain. Client #76 moved her head up and down and in a circular motion while smiling. Client #76 still had blood smeared on her forehead and across the bridge of her nose. CNA #1 again attempted to wipe client #76's forehead with a disposable towelette and the client pushed the staff away making a crying noise. A spot of blood was noted on client #76's right leg of her sweat pants that she was wearing. CNA #1 stated the spot on client #76's clothing was blood from the client's forehead. CNA #1 was asked if she had reported the continued oozing of blood from the injury to the nurse. CNA #1 stated, "No." CNA #1 indicated the nurse and/or the QIDP (Qualified Intellectual Disabilities Professional) had not given the staff any specific guidance of how to supervise and/or assist client #76 in regard to falls. At 11:35 AM LPN (Licensed Practical Nurse) #1 approached</p>		<p>requesting intervention for potential pain when an injury is sustained from a fall. Revised fall procedure to be educated with staff.</p> <p>QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>Staff have been retrained on identification and reporting of abuse and neglect.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.</p> <p>Nursing staff have been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing has been trained to notify ED <u>and</u> DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nursing staff have been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion.</p> <p>The fall assessment will be used by the IDT to assist in development or revision of the fall</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  07/22/2013
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>client #76 and asked the client, "Hey, you alright?" Client #76 did not respond and the nurse left the classroom and returned with a small cup of water and offered it to client #76. Client #76 pushed LPN #1's hand away and refused the water. LPN #1 stated, "OK" and left the room. Client #76 began rubbing her forehead and left eye.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 2:35 PM through 2:50 PM. Client #76 was laying asleep in her bed.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 2:40 PM through 2:45 PM. Client #76 was laying asleep in her bed. No changes were noted in the steri-strips. Client #76's face presented with streaks of dried blood across her forehead, nose and left eye. More bruising was noted around the orbit of her left eye. The steri strip across the bridge of her nose was in place. Client #76's nose was crooked and appeared more swollen than when observed earlier in the day. Throughout observations, client #76 did not have nor was she offered an ice pack.</p> <p>Client #76's record was reviewed on 7/11/13 at 1 PM. Client #76's nursing notes indicated: __ On 4/18/13 the client took a few steps</p>		<p>prevention/safe ambulation plan when needed. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. Administrative, supervisory and nursing staff are to be retrained on the reviewed/revised abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse. Allegations of staff misconduct related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures are in place, that the Executive Director or designee has been notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>Nurses have been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>For all clients with AWOL and/or physical assault in their plans, the BSPs will be reviewed for appropriateness. CST will be</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  07/22/2013	
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>toward the trash can to throw trash away without the use of her walker and lost her balance and fell onto her buttocks.</p> <p>__ On 6/28/13 client #76 lost her balance as she was walking towards her room with her walker and fell backwards hitting the back of her head on the corner of the door frame. "Resident had cut and bump that was bleeding to back of head upon assessment. BP (Blood Pressure) 167/95, P (Pulse) 88 R (Respirations) 18. O2 (blood oxygen level) 98% on room air. Resident cried momentarily but was still alert and oriented. Resident sent to ER (Emergency Room) and came back with staples to back of head."</p> <p>__ On 6/29/13 "Client rested through the night. Noted with 4 staples upper left back of head, dry intact, no s/s (signs and/or symptoms) of infx (infection). At 2 AM BP 162/64, P-81, R-18... Neuro checks wnl (within normal limits)."</p> <p>__ On 7/6/13 The nurse did her monthly body assessments and noted client #76 had old bruising to her upper back. Bruises were yellow in color and starting to fade.</p> <p>__ On 7/8/13 the staples to the back of the client's head were removed.</p> <p>__ On 7/10/13 a floor mat for fall prevention was removed.</p> <p>__ On 7/11/13 at 9:55 AM, at 7:15 AM, "Client fall occurred today at 7:15 am while ambulating with walker to the</p>		<p>reviewed to monitor that current information/interventions are included.</p> <p>Nurses trained on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>For all clients with identified choking risks, the PD or Q will review the outing form for completeness and accuracy in diet orders, staffing levels, etc. The outing form is taken by staff for reference during the activity. If there are additional dining risks (i.e.: individual compliance), that information will also be noted on the outing form. Staff have been trained on the Heimlich and training to competency will be completed by staff annually.</p> <p>Monitoring for implementation of behavior support plans will be added to the active treatment observations done by the QIDP. The fall care/risk plans for any individual with a history of falls at night (multiple falls or falls with injury) will be reviewed by the IDTs for inclusion of interventions specific to this need. Nursing and CNA staff will be retrained on any revisions, and revisions will be updated on the CST.</p> <p>Clients with a fall risk plan will have their shoes assessed for appropriateness and fit. The use of gripper socks will be</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  07/22/2013	
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>bathroom stumbled and fell face first. Has an area raised to forehead open area small v shape gash measuring 3 cm x 3 cm on each side. And skin tear to bridge of nose. Steri strips applied to forehead and bridge of nose. Tylenol admin (administered) as ordered for discomfort. V/S (vital signs): 96.2 [temperature], 195/133 [blood pressure], 19 [respirations], O2 98 [Oxygen Saturation in the blood]." "[Name of doctor] informed, family notified and DON (Director of Nursing)/ED (Executive Director) made aware of client status." __ On 7/11/13 at 2:13 PM indicated "Neuro checks completed at 7:15 AM, 9:15 AM, 10 AM, 12 PM, 1:15 PM. Client was seen by [name of doctor] at 1 PM advise nursing that client did not need to be sent out to ER. Steri strips intact scant blood noted...."</p> <p>Client #76's BIRs (Behavior Incident Reports) indicated: __ 7/11/13 at 7:40 AM, client #76 was sitting in a chair in her bedroom when the staff prompted the client to go to the bathroom to get ready for breakfast. The report indicated client #76 was walking to the bathroom "then fell face forward on the floor." The report indicated the staff assisted the client up and to sit in the chair and then notified the nurse. __ 7/11/13 at 7:15 AM, "Client had fallen,</p>		<p>encouraged and staff will be inserviced on the need to complete a BIR for refusal to follow fall prevention protocols. As part of active treatment training, CNAs will be inserviced on the need to keep people awake in classrooms and common areas and methods to help prevent people from sleeping in chairs. An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of documentation, staff interviews (from all 3 shifts if the fall/injury was not observed), and a conclusion including what is being done to help prevent reoccurrence. Staff will be retrained that they cannot use other people's money for any reason without OK from PD/business office. (cannot ever use Soc. Sec. money. Person has to be able to give informed consent to buy/give gifts with earned money. Staff have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions</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  07/22/2013	
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>nurse was doing assessment. Client was getting aggressive with staff while taking B/P. Caused B/P to be high." __7/11/13 at 7:15 AM client #76 was given an ice pack for her forehead 5 times. __7/11/13 at 9:45 AM client #76 was picking at her forehead and picking at her bandages after a fall. Nurse was notified that client was picking at forehead.</p> <p>Client #76's Neurological Assessment form of 7/2013 in regard to the fall of 7/11/13 indicated LPN #1 had conducted a neurological assessment on client #76 on 7/11/13 at 7:15 AM, 9:15 AM, 10 AM, 12 PM, 1:15 PM and 7:30 AM. The form indicated at 7:15 AM client #76's BP was 195/133, at 9:15 AM 132/46, at 10 AM 192/33, at 12 PM 135/45, at 1:15 PM 138/56 and at 7:30 AM 142/89. When this surveyor asked LPN #1 for this information at 3:15 PM, LPN #1 indicated she had not documented all of the assessments and would have to document before she could give copies. LPN #1 then proceeded to add to the Assessment forms the assessments for 7/11/13 at 1:15 PM and 7:30 AM.</p> <p>Client #76's Neurological Assessment forms of 6/2013 in regard to the falls of 6/6/13 and 6/28/13 indicated the client's neurological assessments were conducted</p>		<p>in cases of blood.</p> <p>IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Client Advocates will assure process followed when there are cases of allegation of neglect and abuse with follow up with ED/DNS when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director. QIDPs will monitor documentation folders to check that current BSPs are in the classrooms for ready access by CNAs. QIDPs will add monitoring for the appropriate implementation of BSPs and this monitoring will be added to the active treatment</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  07/22/2013
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>once a shift for 72 hours.</p> <p>A 7/11/13 fax note to the facility doctor indicated a fax was sent at 7/11/13 at 9:16 AM to the facility doctor. The fax indicated "Client (#76) has had 3 falls in the last 30 days, 2 occurred within the last 7 days of each other. Client fall occurred today at 7:15 am while ambulating with walker to the bathroom stumbled and fell face first. Has an area raised to forehead open area small v shape gash measuring 3 cm (centimeters) x 3 cm on each side. And skin tear to bridge of nose. Blood noted to both area minimal (sic)."</p> <p>The 7/11/13 (no time documented) physician's progress note indicated client #76 had experienced a fall causing a "v" shape laceration on her mid-forehead. The note indicated "Forehead as (sic) a soft tissue swelling with surrounding redness - especially over left forehead side. There are smaller areas of redness noted over nose.... Pupils are equal in size and eye movements are synchronized. There is dried blood overlying the laceration. Patient is noted to be alert to light, sound, voice and at her normal mental state. She is moving all extremities well and her balance is back to normal. Patient's BP was reported to be around 190 systolic after the injury but returned to a systolic around 140 after 20 minutes or so</p>		<p>sheets.</p> <p>Diet orders, care/risk plans, dining books and CST will be updated following any change to diet orders. Staff will need to sign off on updated information. Program Directors review outings as to effectiveness, safety and client interest both before and after the trip.</p> <p>Fall risk plans for those at high risk for falls are reviewed by the Client Advocates for quality assurance purposes.</p> <p>Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval.</p> <p>THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved.</p> <p>The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time of the observation. Rounds include resident appearance and cleanliness.</p> <p>The PD will review the Environmental Round observations weekly and complete retraining as needed.</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  07/22/2013
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>according to her nurse. Patient appears to have suffer (sic) no serious injury to intracranial area, but will send to ER (Emergency Room) to assure she is normal for her."</p> <p>Client #76's risk plan of 10/12/12 for falls indicated client #76 is "At risk for injury from falls or mobility trauma related to possible bone marrow suppression as a result of hypocalcemia as side effect of Depakote." The plan indicated the staff were to encourage client #76 to slow down when walking, wear proper fitting shoes and to be aware of her surroundings. The plan indicated the staff were to encourage client #76 to use her walker and to pay attention to her surroundings when ambulating and the staff were to provide stand by assistance while exercising. Client #76's risk plan indicated no revisions or updates due to the client's recent falls in April, June and July.</p> <p>Client #76's ISP (Individualized Support Plan) of 11/1/12 indicated client #76 ambulated with independence via a wheeled walker and was at risk for falls. The ISP indicated a physical therapist saw client #76 on 10/30/12 which "revealed [client #76] tends to forget her forward wheeling walker and ambulates to short distances. Needs supervision for toileting</p>		Corrections to be completed by August 21, 2013.		

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  07/22/2013	
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>and maximum verbal cues to use her walker."</p> <p>Client #76's IDT (Interdisciplinary Team) notes indicated:</p> <p>__ On 4/26/13 the IDT reviewed client #76's fall on 4/18/13 when she lost her balance as she was taking her dinner plate to the cart. No specific changes were made to her plan of care.</p> <p>__ On 6/12/13 the IDT reviewed client #76's fall in the dining room during church service on 6/7/13. The staff reported client #76 was walking and tripped on a chair and fell, hitting her head on another chair and sustaining a small cut on the bridge of her nose and a bump on her forehead. The team indicated it was an accident and the staff were directed to ensure that any tripping hazard that might impede safe movement of the client be removed.</p> <p>__ On 7/9/13 IDT notes indicated client #76 was sent to the hospital ER on 6/28/13 due to a fall she had in her bedroom. Client #76 was walking with her walker into her bedroom when she fell as she turned around hitting her head on the door frame resulting in lacerations to the back of her head. As a result, the client was treated and released with staples to the laceration. The IDT made no further recommendations and/or changes to the client's plan of</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  07/22/2013	
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>treatment/care.</p> <p>Client #76's ISP/record did not indicate any revisions by the IDT (Interdisciplinary Team) due to client #76's falls in April, June and July to ensure client #76's safety due to falls with injury.</p> <p>Client #76 was interviewed on 7/11/13 at 9:45 AM. When asked how she injured her head, client #76 stated, "... fell."</p> <p>CNA #1 was interviewed on 7/11/13 at 9:50 AM. CNA #1 indicated client #76 had fallen the morning of 7/11/13. CNA #1 indicated client #76's forehead was injured.</p> <p>During interview with CNA #12 on 7/11/13 at 11:20 AM in the 2 West classroom where client #76 was sitting, CNA #12 was asked how the staff were to supervise and/or monitor client #76 and had there been any recent changes/directions and/or training in regard to client #76 in regard to her falls and head injury. CNA #12 stated, "Oh, I don't know. She's not my person." At the time of the interview CNA #1 had stepped out of the room to assist with another client and CNA #12 was alone in the classroom with client #76 and 4 other clients.</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  07/22/2013
--	---	--	---

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>Interview with CNA #1 on 7/11/13 at 11:50 AM indicated nursing staff and/or programming staff had not provided or informed the direct care staff in any changes in client #76's care and/or in the level of supervision the staff were to provide client #76 to ensure her safety due to recurrent falls.</p> <p>Interview with the facility physician on 7/11/13 at 12:30 PM indicated he had not been notified of client #76's fall on 7/11/13 at the time of the interview.</p> <p>Interview with the facility DON (Director of Nurses) on 7/11/13 at 1:40 PM indicated whenever there was a client fall with an injury and/or head injury, the facility nurse was to notify the DON. The DON stated she had not been notified of client #76's fall and head injury at the time of the incident and the LPN "should have called me. I'm not sure why she didn't. She usually does." The DON indicated the nurse should have taken client #76's blood pressure again, called the doctor and if she couldn't reach the doctor, the nurse should have sent the client to the emergency room for an evaluation due to the elevated BP and head injury. The DON indicated the blood pressure machine could have been faulty and the nurse should have repeated the</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  07/22/2013
--	---	--	---

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>client's blood pressure after getting a reading of 195/133. When asked what was the facility policy and practice of care in regard to clients with head injuries, the DON stated the facility practice was for the nurses to do a neurological assessment "at least once a shift." The DON stated, "But as a nurse, I know it is more frequent and we usually do neuro assessments every 2 or 3 hours for the first 72 hours after an injury, we always do them more often."</p> <p>CNA #1 was interviewed on 7/11/13 at 2:41 PM. CNA #1 stated, "I was working with [client #76] this morning when she fell. I was standing at [client #76's] bed while she was using her walker to go to the restroom. I looked up and [client #76] was laying with her face on the floor in front of her restroom. There was blood splattered on the walls and all over the floor." CNA #1 stated, "I saw the amount of blood. So, I called the other CNA, [CNA #2], and the nurse, [LPN (Licensed Practical Nurse) #1]. [CNA #2] came and helped me get [client #76] up. [LPN #1] came in and helped look at [client #76]." When asked if LPN #1 had given her any instructions regarding how to monitor client #76's head injury, CNA #1 stated, "No, no one gave us any instructions." CNA #1 indicated client #76 was asleep in her bed. CNA #1 stated, "[Client #76]</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  07/22/2013
--	---	--	---

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>laid down around 1:15 PM. [Client #76] just fell asleep about 20 minutes ago."</p> <p>Interview with LPN #1 on 7/11/13 at 2:50 PM indicated after client #76's fall she took the client's vital signs and did a neurological assessment. LPN #1 indicated client #76's blood pressure reading after the fall was 195/133. LPN #1 stated the client was "combative" and she had difficulty taking her blood pressure, "So that's why it was probably so high." When asked if she had retaken client #76's blood pressure she indicated she had. When asked when and was it documented, LPN #1 stated "about 15 or 20 minutes later" but did not indicate what the client's blood pressure was and had not yet documented her results. When asked if she had notified the physician and/or consulted with anyone in regards to client #76's head injury, elevated blood pressure and the possible need for further assessments and/or being sent for an evaluation due to head trauma, LPN #1 stated she telephoned the physician's office "around" 7:30 AM but no one answered the phone and she had sent a fax to the physician, but the fax machine wasn't working correctly. LPN #1 indicated she had not notified the DON. When asked if the staff should have reported to her the client's injury on her forehead was still bleeding, the LPN</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  07/22/2013	
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>indicated yes and the staff had not said anything to her. When asked what was the facility policy/protocol for head injuries in regard to monitoring the client and what the staff should be monitoring, the LPN stated, "I didn't know we had a policy or anything to do with head injuries." LPN #1 indicated she had not given the staff any additional and/or specific instructions in regard to client #76's head injury and how the staff were to monitor client #76, the level of activity client #76 was to be involved with, if and when client #76 was to lay down and what the staff were to report to her. After interviewing LPN #1, the LPN was asked for documentation of her physical assessments and paper work of client #76. The LPN indicated she had not documented all of the information as she did not have time. This surveyor observed this nurse completing her documentation of the 1:15 PM and 7:30 AM neuro assessments onto the Neurological Assessment form and completing the BIRs for 7/11/13 at 3:15 PM.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1 and Program Director (PD) #3 on 7/11/13 at 5:25 PM indicated there had been no specific changes made to client #76's ISP in regard to client #76's falls and/or how the staff were to supervise and/or monitor</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  07/22/2013
--	---	--	---

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>client #76 to protect client #76 from recurring injury due to falls. The PD #3 indicated the client was last assessed by PT (Physical Therapy) on 10/30/12. The PD #3 stated "I was going to have her reassessed after this last fall with injury." When asked why the client was not reassessed after the fall with injury in June, the PD indicated the client should have been seen by PT and was not sure why she wasn't.</p> <p>2. A facility BDDS (Bureau of Developmental Disabilities Services) report of 6/16/13 reviewed on 7/9/13 at 1 PM indicated on 6/15/13 at 7:35 AM client #149 was "seated in wheelchair in 3 west hallway near the wall awaiting transfer to ER (Emergency Room) for evaluation and treatment of distended abdomen and signs of discomfort. [Client #115] left her unit and turned [client #149] over to the floor in his wheelchair. Staff redirected [client #115] to her unit and nursing administered first aid. Nursing called 911 due to laceration to head behind ear on [client #149]. [Client #149] was transferred to [name of hospital] for evaluation and treatment. He remains in patient at [name of hospital] at this time with diagnosis of pneumonia. He is also being monitored at [name of hospital] due to previous diagnosis of Functional Disorders of the Stomach....</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  07/22/2013
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>Staff working with [client #149] on 2nd floor have received further training to NOT leave residents in hallway unattended...."</p> <p>The investigative report of 6/15/13 indicated the staff reported seeing client #115 walking down the west corridor towards client #149, and upon approaching him, throwing his wheelchair to the side. Staff and nurse report immediately intervening.... Laceration noted to left side of [client #149's] head. [Client #149] was transferred by EMS [Emergency Medical Services] after 911 was called due to head injury. Resident received 3 staples to left side of head...."</p> <p>Telephone interview with the DON and the Adm (Administrator) on 7/16/13 at 10 AM indicated clients are never to be left in the hallway unattended. The DON indicated nursing staff should have assigned a staff to stay with client #149 until he could be transferred out to the hospital for evaluation.</p> <p>Telephone interview with PD #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM indicated clients were never to be left alone and unsupervised in a hallway.</p> <p>Review of the facility policy of Reporting</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  07/22/2013
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>Alleged Violations dated 5/2001 on 7/8/13 at 1:58 PM indicated neglect to be failure to provide goods and services necessary to avoid physical harm, mental anguish or illness.</p> <p>3. On 7/8/13 at 2:50pm, the facility's reportable incidents were reviewed and indicated the following for client #37. -A 2/25/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 2/24/13 at 2:00pm, indicated client #37 had gone out of the facility to church with staff and a group of clients. After church the group went out to eat at a local restaurant. The report indicated client #37 ordered a chicken sandwich, fries, coke, and a small milkshake. The report indicated "Staff with [client #37] cut the sandwich into quarters (size bites). [Client #37] took a few bites of her food and began to choke. The Heimlich was done, [client #37] coughed up several pieces of food onto her plate." The report indicated client #37 was "on a mechanical soft diet" before the incident and the staff on the outing was suspended pending investigation.</p> <p>-A 3/4/13 Follow up BDDS report indicated client #37 was on a mechanical soft diet before the incident. The follow up report indicated the staff had cut up client #37's "grilled chicken" sandwich</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  07/22/2013
--	---	--	---

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>into quarters, client #37 consumed a "few bites," choked, staff initiated the Heimlich Maneuver with no results, a restaurant customer who was identified as a community Registered Nurse assisted with the Heimlich Maneuver, and the food was dislodged enabling client #37 to breathe. The staff involved with the incident was terminated from employment as the result of client #37 not having the correct food consistency.</p> <p>On 7/11/13 at 2:20pm, client #37's record was reviewed. Client #37's undated "Quick Diet Reference" from the facility's unit where client #37 lived, indicated client #37's name, "Mech. (Mechanical) soft" diet. Client #37's 7/10/13, 3/28/13, and 8/29/2011 "Physician's Order," and client #37's 3/12/13 "Nursing Assessment" indicated client #37 was at risk to choke and was to receive a mechanical soft diet. Client #37's 4/9/13 ISP (Individual Support Plan) indicated she was at risk to choke and was to receive a mechanical soft diet.</p> <p>On 7/11/13 at 9:50am, an interview with Administrative (Admin.) Staff #2 was conducted. Admin. Staff #2 indicated client #37 was not served the correct texture of diet while on an outing on 2/24/13 and choked as the result. Admin. Staff #2 indicated a mechanical soft diet</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  07/22/2013
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>is a diet that was mechanically altered. Admin. Staff #2 indicated the meat should not have been quartered, the meat should have been cut up into small pieces or ground up. Admin. Staff #2 indicated the facility staff neglected to ensure client #37 had a mechanical soft diet.</p> <p>4. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's 12/14/12 reportable incident report indicated "...Housekeeping staff alerted nursing that [client #132] fell on 12/12/2012 in her room in her doorway after housekeeping mopped the floor and placed a wet floor sign in her room. [Client #132] was sleeping in her bed at the time housecleaning was cleaning her room. [Client #132] experienced a laceration to the outer aspect of the eyebrow on her left eye. Nursing immediately assessed [client #132] and had [client #132] sent via ambulance to [name of hospital] ER (emergency room) for evaluation of her wound. [Client #132] returned from the hospital on 12/14/2012 with a new diagnosis of facial laceration and nasal bone fracture. The laceration to the eyebrow of the left eye was closed with glue by the physician in the ER. A CT scan performed in the ER</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  07/22/2013	
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>concluded that there were fractures in the upper nasal area and the facial area below the left eye. CT was unable to determine the age of these fractures. However, [client #132] does have a history of falls and has recently had fall events on 12/3/2012 and 12/8/2012; of which the fall on 12/3/2012 resulted in injury involving bruising to both eyes. The event on 12/8/2012 resulted in no injury. [Client #132] has been on 15 minute checks and will be closely monitored by staff. [Client #132] has an intervention plan regarding falls and has received an order for a urinalysis and are pending the results of this lab currently. Client was seen by physical therapy on 11/8/2012 which indicated no decline in client's gait...[Client #132] has an order to follow with a plastic surgeon to determine the extent of the fractures and if any corrective procedure needs to be scheduled."</p> <p>The facility's 12/21/12 follow-up report indicated "[Client #132's] fracture and laceration were sustained on the fall that occurred on 12/14/2012. According to the facial CT performed at the hospital, [client #132] sustained simple fractures along the nasal bone and the cheek bone below the left eye...Staff were aware of [client #132's] location at the time of the incident but were not aware the floor was</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  07/22/2013	
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>being mopped...The results of the urinalysis obtained on 12/18 showed no abnormal findings. Client was seen by a plastic surgeon on 12/20 and it was concluded by the plastic surgeon that surgery was not indicated to apply ice as needed and leave head of be (sic) elevated...DNS (Director of Nursing Services) has instructed housekeeping to communicate to all staff on the unit when mopping and cleaning of client's (sic) rooms are taking place. Housekeeping staff have been instructed not to mop bedrooms when clients are present and to return when clients are not in rooms or participating in activities. [Client #132] is to remain on 15 minute checks and is to be assisted with ambulation as tolerated by [client #132]." The 12/21/12 follow-up report indicated it was not known if client #132 had shoes on at the time of the fall. The follow-up report also indicated client #132's psychiatrist reduced the client's behavioral medication (Ativan) to help "increase awareness."</p> <p>The facility's undated Hospital/ER Report indicated "...During and (sic) investigation of a fall [client #132] sustained on 12/8, 3rd floor staff stated that [client #132] was screaming and wandering more often than usual. It was stated that client was sleeping less and becoming more easily agitated than</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  07/22/2013
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>usual...."</p> <p>The facility's reportable incident reports, Fall Reports, Hospital Reports, BIRs and/or investigations indicated the following:</p> <p>-12/3/12 "Resident (client #132) fell in doorway walking out of room with hands full carrying clothing. Resident struck left side of head and left eye as well as left shoulder on door frame. Nursing notified, and redness noted to sclera of left eye and left eyelid. Redness also noted to left shoulder. No further signs of injury noted at this time, however resident is subject to bruising to left face, shoulder and eye. Neurological assessments completed by nursing and no abnormalities noted...Staff will continue to monitor for further falls and follow BSP (Behavior Support Plan), Nursing will continue to monitor for further signs of injury or discomfort."</p> <p>The facility's undated Fall Report indicated client #132 hit her face on the door jam walking out of her room at 3:50 AM. The Fall Report indicated "...[Client #132] has a history and pattern of periods of increased mania which includes not sleeping...Conclusion: [Client #132] has a history of falls related to carrying objects and maladaptive behaviors. She</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  07/22/2013
--	---	--	---

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>has a fall prevention plan. [Client #132] will continue to be monitored, and redirected to slow down pace...."</p> <p>-12/8/12 "Client up all night yelling, screaming, disturbing peers, running-sleep drunk walking, falling on floor x (times) 3 on buttocks and both sides."</p> <p>An attached 1/24/13 Interdisciplinary Team (IDT) note indicated "A review of [client #132's] chart finds that the formal notes from the IDT were not typed. [Client #132] was up all night yelling and running, She was unsteady and staff described her walk as 'drunk.' She fell to floor 3 times, landing on her buttocks and both sides. There was no apparent injury. Recommendations: [Client #132's] behavior plan addresses manic cycles and should continue to be implemented...."</p> <p>-12/10/12 Client #132 got up at night and fell trying to walk out of her bedroom to her buttocks. The Fall report indicated client #132 "fell twice trying to get up." No injuries noted.</p> <p>-12/12/12 Client #132 was walking down hallway with blood dripping from the top of client #132's left side of her scalp. The reportable incident report indicated client #132's fingernails were long, had a</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  07/22/2013	
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>"tantrum" on 12/11/12, 12/12/12 and repeated falls.</p> <p>-1/12/13 "Client #132] was heading into the dining room and was redirected by the hall monitor. She did not respond. The hall monitor called for [client #132's] staff- in the interim, a peer came out and told staff that [client #132] had fallen. She had a laceration to her lip and was taken to the ER." The undated Hospital/ER Report indicated the incident occurred at 8:30 PM on 1/12/13. The report also indicated client #132 received one stitch to her upper lip. The report indicated "...Conclusion: [Client #132] has had multiple falls over the past month. She has been assessed for UTI (Urinary Tract Infection), which was negative. Her physician has been notified. To help prevent future falls, [client #132's] fall care plan has been revised. As well, North Willow is instituting a program to increase awareness for staff of clients who are at greater risk of falls. Staff will continue to monitor [client #132's] shoes to assure they fit properly and are on the right feet. She will be prompted to slow her rate of walking to help reduce the risk of further falls...."</p> <p>An attached 1/28/13 IDT note indicated client #132's fall plan was revised to</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  07/22/2013	
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>include a program (leaf program) to "...increase awareness for staff of clients who are at greater risk of falls...."</p> <p>-4/20/13 Client #132 fell asleep in a chair and fell out of the chair. No injuries noted.</p> <p>-4/21/13 Client #132 left her unit to go back to dining room. The BIR indicated when the client was redirected away from an area where another client had a behavior, client #132 fell to the floor pulling staff to the floor with her. The BIR indicated client #132 slipped on the floor.</p> <p>An attached 4/22/13 IDT note indicated "...[Client #132] fall (sic) due to another resident throwing her plate on the floor and causing [client #132] to slip and fall...Conclusion: Staff will redirect [client #132] when there are unsafe areas. Staff will ensure areas are save (sic) and free of spills, if able...."</p> <p>-6/15/13 "Client tripped and fell and hit head on side of table causing a laceration on her left eye brow. Client sent to ER for eval (evaluation); and treatment. Client returned from ER a few hours later. Nursing following discharge instructions."</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  07/22/2013
--	---	--	---

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>The facility's 6/15/13 ER/Hospital Report indicated client #132 received 4 sutures to her left eyebrow due to the fall. The report indicated "...[Client #132] has a history of falls. She has a fall risk plan. She has fallen twice previously this year on 4/20/13 and 4/21/13...Staff will continue to encourage [client #132] to slow down and be more aware of her surroundings. She does have a fall risk plan r/t (related to) impaired safety awareness."</p> <p>An attached 7/3/13 IDT note indicated client #132 fell in the classroom and was sent out to the ER for evaluation receiving 4 sutures to left eye brow. The 7/3/13 IDT neglected to put any additional safeguards in place to protect client #132 from falls with injuries and/or fractures.</p> <p>Client #132's record was reviewed on 7/12/13 at 9:44 AM. Client #132's 6/24/13 physician's orders indicated client #132's sutures were removed on 6/24/13 and Keflex 500 milligrams (antibiotic) was ordered three times a day for 7 days "for infected suture area."</p> <p>Client #132's 6/24/13 Progress Note indicated "Green/yellow drainage noted from area to left eyebrow. Three sutures intact. Client picking at area. Staples x 3 intact to left eyebrow. Drainage noted at</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  07/22/2013
--	---	--	---

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>aea (sic). Client C/O (complains of) pain to area."</p> <p>Client #132's 11/8/12 Physical Therapy (PT) Evaluation indicated client #132 "...needs 24/7 supervision for safety and H/O (history of) falls." The PT evaluation indicated client #132's supervision varied "from remote to close dep (depending) on her behaviours (sic)...." The PT eval indicated client #132 fell on 8/5/12 and 7/10/12. The PT evaluation indicated a strengthening program was developed.</p> <p>Client #132's 3/27/13 PT Screen indicated "Pt (patient) amb (ambulates) (I) (independently) to all distances. When she has a lot of stuff in her hands; she tends to lean fwd (forward) when ambulating (prompt the staff to assist PRN (as needed)). 1st shift staff redirects her to clean out her hands so she can ambulate safely (without) assist. She does not need gait belt but req (require) remote supervision along (with) vcs (verbal cues). When walking fast- She walks on her toes and needs redirection to pace herself." The PT screen indicated "Physical Therapy evaluation NOT indicated."</p> <p>Client #132's 8/5/12 Risk plan indicated client #132 had a risk plan for a fractured</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  07/22/2013
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>hand at that time due to a fall.</p> <p>Client #132's 1/16/13 fall risk plan indicated client #132 had a history of falls. The fall risk plan indicated the following (not all inclusive):</p> <p>"-Client has less ability to focus on near objects with aging process as well as with depth perception. 1.) Encourage client to use W/C (wheelchair) prn 2.) Utilize gait belt whenever client is attempting to ambulate unassisted.</p> <p>-Client to have P.T. evaluation to determine if client would benefit from strengthening or balancing programs.</p> <p>-Keep environment well lit and free of clutter.</p> <p>-Remind client to decrease weight of objects in her book bag if bag appears too full. Heavy book bag can cause client to lose her balance when walking.</p> <p>-Report changes of condition to MD (medical doctor) prn.</p> <p>-Staff to remind client to slow down when walking, and to use hand rails in hallway when possible.</p> <p>-Staff to remind client upon waking, after</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  07/22/2013	
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>meals, and before going to bed to toilet.</p> <p>-Staff will ensure that client is wearing her designated footwear and wearing them on correctly.</p> <p>-Staff will prompt and assist client when walking through wet areas and areas with clutter."</p> <p>Client #132's IDT notes dated 7/3/13, 5/10/13, 4/22/13, 2/28/13, 1/28/13 and 1/24/13 indicated the facility neglected to revise client #132's risk plans for falls. The facility neglected to indicate how client #132 was to be monitored/supervised, when awake at night, to ensure the client was monitored/supervised to prevent falls in the client's bedroom, and/or to prevent injuries which resulted in ER trips/sutures/fractures. Client #132's 3/13 PT evaluation and/or 10/12 Individual Support Plan (ISP), and/or 1/13 risk plan did not specifically indicate/define "remote supervision."</p> <p>Interview with Program Director (PD) #2 on 7/12/13 at 1:30 PM indicated client #132 was a fall risk. PD #2 indicated the facility initiated 1 minute checks after the falls with injuries. PD #2 indicated client #2 was no longer on 15 minute checks. PD #2 indicated fall assessments were</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  07/22/2013	
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>also completed after each fall. PD #2 indicated client #132's risk plan had not been revised since 1/13. PD #2 indicated client #132 did not utilize a gait belt and did not require staff to be with the client when ambulating. PD #2 indicated client #132 would wake up at night and get out of her bed. PD #2 indicated client #132's ISP and/or risk plan did not indicate how client #2 was to be supervised and/or clearly define remote supervision to prevent further injuries/fractures.</p> <p>5. Confidential interview A indicated an allegation of abuse had been reported to the facility regarding a nurse and client #141 on 7/10/13.</p> <p>The facility's 7/10/13 reportable incident report indicated on 7/10/13 at 5:00 PM, "It was reported that [RN #8], RN, had referred to [client #141] using inappropriate language after [client #141] had hit her on the top of her head and spilled water/medications on her. It was confirmed the comment was said, but initial information is that it wasn't directed to [client #141]. Immediate corrective action was taken. [RN #8] was suspended today as well to allow for a thorough investigation of the incident. Internal investigation is in progress."</p> <p>Interview with administrative staff #2 on</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  07/22/2013
--	---	--	---

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>7/11/13 at 10:17 AM indicated when asked if the facility had reported any allegations of abuse and/or neglect within the last 24 hours, administrative staff #2 stated "No, just with [client #98]."</p> <p>Interview with administrative staff #1 and #2 on 7/11/13 at 10:20 AM indicated no allegations of abuse had been reported to the administration from 7/10/13 to 7/11/13. When the surveyor went to report an allegation of abuse, administrative staff #1 indicated she was aware of an incident involving RN #8 and client #141. Administrative staff #1 indicated she and the Director of Nursing were told of the allegation on 7/10/13 by a Program Director. Administrative staff #1 indicated she (administrative staff #1) was told there were several people in the area when RN #8 made the comment about client #141. Administrative staff #1 indicated she was not sure if any other clients were present in the area when RN #8 made the statement to another staff person, but indicated other people were in the area. Administrative staff #1 stated "[RN #8's] statement about client #141 was "inappropriate." Administrative staff #1 indicated RN #8 admitted to making the statement. Administrative staff #1 indicated she did not see the statement as an allegation of verbal abuse. Administrative staff #1 indicated RN #8</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  07/22/2013	
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>was reprimanded on 7/10/13 for the statement. Administrative staff #1 indicated RN #1 was not suspended on 7/10/13 after the allegation was made. Administrative staff #1 indicated no investigation was initiated after the 7/10/13 initial report until the incident was questioned on 7/11/13.</p> <p>The facility's 7/11/13 Daily Nursing Schedule was reviewed on 7/11/13 at 10:00 AM. The 7/11/13 nursing schedule indicated RN #1 was scheduled to work the 2:30 PM to 11:00 PM shift on 7/11/13. The facility neglected to suspend the registered nurse/professional staff in regard to an allegation of verbal abuse involving client #141 on 7/10/13 as RN #1 was allowed to continue to work her shift after the allegation was made.</p> <p>The facility neglected to recognize an allegation of verbal abuse when reported, and/or neglected to report the allegation of verbal abuse to state authorities until the 7/10/13 incident was questioned on 7/11/13. The facility neglected to initiate an investigation after the initial report was made on 7/10/13 to determine if RN #1 and/or other staff spoke to and/or about other clients in similar manner, and/or to determine if the allegation was verbal abuse versus inappropriate interaction/conduct in regard to client</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  07/22/2013
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	
	#141.  The facility's policy and procedures were reviewed on 7/8/13 at 1:58 PM. The facility's May 2001 policy and procedure entitled Reporting Alleged Violations indicated "It is the responsibility of all associates to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property. It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source misappropriation of resident property. 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 misappropriation 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. The facility investigates each such alleged violation thoroughly and reports the results of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law." The facility's May 2001 policy indicated the following definitions (not all inclusive):				

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  07/22/2013	
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>"Abuse the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability comprehend or disability...Neglect means failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent..." The facility's policy indicated "...Any associate who suspects an alleged violation immediately notifies the ED, (executive director) or designee. The ED notifies the appropriate state agency in accordance with state law and the regional vice president...."</p> <p>6. The facility failed to report all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator and/or to state officials per state law for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141. Please see W153.</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  07/22/2013
--	---	--	---

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. The facility failed to conduct thorough investigations in regard to fractures for clients #15, #16 and #55. Please see W154.</p> <p>8. The facility failed to immediately suspend a professional staff in regard to an allegation of verbal abuse for client #141. Please see W155.</p> <p>3.1-28(a)</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  07/22/2013	
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			
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>Based on observation, interview and record review for 12 of 96 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator and/or to state officials per state law for clients #20, #27, #71, #73, #76, #94, #96, #118, #135 and #141.</p> <p>Findings include:</p> <p>1. Confidential interview A indicated an allegation of abuse had been reported to the facility regarding a nurse and client #141 on 7/10/13.</p> <p>The facility's 7/10/13 reportable incident report indicated on 7/10/13 at 5:00 PM, "It was reported that [RN #8], RN, had referred to [client #141] using inappropriate language after [client #141] had hit her on the top of her head and spilled water/medications on her. It was confirmed the comment was said, but initial information is that it wasn't</p>	W000153	<p>W153</p> <p>I QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>Reinstated the flow chart: BIR/Fall Assessment - for resident 76's nurse to determine if need to call ED - BIR box for follow-up. THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved.</p> <p>Both individuals have been assessed by nursing and bruises observed at the time of the survey have resolved, however another bruise has been noted on resident 76 and is being investigated at this time.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Allegations of staff misconduct</p>	08/21/2013			

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  07/22/2013	
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>directed to [client #141]. Immediate corrective action was taken. [RN #8] was suspended today as well to allow for a thorough investigation of the incident. Internal investigation is in progress."</p> <p>Interview with administrative staff #2 on 7/11/13 at 10:17 AM indicated when asked if the facility had reported any allegations of abuse and/or neglect within the last 24 hours, administrative staff #2 stated "No, just with [client #98]."</p> <p>Interview with administrative staff #1 and #2 on 7/11/13 at 10:20 AM indicated no allegations of abuse had been reported to the administration from 7/10/13 to 7/11/13. When the surveyor went to report an allegation of abuse, administrative staff #1 indicated she was aware of an incident involving RN #8 and client #141. Administrative staff #1 indicated she and the Director of Nursing were told of the allegation on 7/10/13 by a Program Director. Administrative staff #1 indicated she (administrative staff #1) was told there were several people in the area when RN #8 made the comment about client #141. Administrative staff #1 indicated she was not sure if any other clients were present in the area when RN #8 made the statement to another staff person, but indicated other people were in the area. Administrative staff #1 stated</p>		<p>related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures are in place, that the Executive Director or designee has been notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse.</p> <p>Administrative, supervisory and nursing staff are to be retrained on the abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>Train nursing on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>Staff have been trained that on day and evening shifts they are to assess each person they are serving with regard to the condition of their skin and report any issues no matter how small for assessment to assure any unknown issues are uncovered and reported for investigation.</p> <p>IV Client Advocates will assure process followed when there are cases of allegation of neglect and abuse with follow up with ED/DNS</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  07/22/2013
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>"[RN #8's] statement about client #141 was "inappropriate." Administrative staff #1 indicated RN #8 admitted to making the statement. Administrative staff #1 indicated she did not see the statement as an allegation of verbal abuse.</p> <p>2. On 7/8/13 at 2:50pm, the facility's reportable incident reports were reviewed for the period from 7/8/2012 through 7/8/2013 and indicated the following incidents of late reporting to the administrator and/or to BDDS:</p> <p>-A 7/8/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 7/6/13 at 12:00pm, indicated client #73 had an unknown bruised (no size documented) area to his right leg.</p> <p>-A 7/1/13 BDDS report for an incident on 6/28/13 at 10:00am, indicated client #118 complained of pain. Client #118 was assessed by the nurse who identified an unknown 6.5 inches by 3 inches bruise on client #118's right arm. Client #118 indicated the injury was from another client and later told the nurse she had fallen out of bed.</p> <p>-A 5/13/13 BDDS report for an incident on 5/10/13 at 9:15pm, indicated HKKP</p>		<p>when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director. Corrections to be completed by August 21, 2013.</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  07/22/2013	
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>(Housekeeping Staff) #50 had notified the Nursing Supervisor of an allegation of abuse that she heard CNA (Certified Nursing Aide) #49 allege that CNA #48 had "hit" client #94 in the chest and was "unsure" of the date and time of the event. Nursing checked client #94 and no injuries were noted.</p> <p>-A 1/17/13 BDDS report for an incident on 12/31/12 at 4pm, indicated the facility administrative staff was aware of incident on 1/9/13. The report indicated "For additional information regarding the finding regarding the handling of client funds in regard to the purchase of pop/snacks. The information was released by the housekeeping staff that reported the original allegation regarding [CNA (Certified Nursing Aide) #50 and Client #141] stated that [CNA #51]...told the [HKKP staff] that on December 31 not all pop was being purchased and that sodas were being poured into glasses so that drinks could be shared." The allegation was "not substantiated."</p> <p>-A review of the undated 12/31/12 investigation indicated the facility staff did not immediately report to the administrator an allegation of financial exploitation of client #141's money and pop. The undated investigation indicated "...An additional outcome of the</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  07/22/2013
--	---	--	---

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>(12/31/12 allegation of abuse) investigation raised a concern regarding the handling of client funds in regard to the purchase of pop/snacks." The investigation results indicated "the initial concern was that not all pop was being purchased and that sodas were being poured into glasses so that drinks could be shared. This concern was not founded. What was determined was that on Tuesday's everyone gets pop money gets pop (sic). On the weekends, not all people get pop. [CNA #50] stated that for those people who are not behavioral, he will share the pop by pouring it into cups because it's not fair for some to get pop and not everyone, and it also leads to behaviors (sic). [CNA #50] will be retrained on the need to protect individual resources (client #141's money) and not share one person's items with another."</p> <p>-A 1/7/13 BDDS report for an incident on 1/5/13 at 7:12am, indicated client #27 had an unknown injury which measured 2cm (centimeter) area inside his left toe and a blister to his toe.</p> <p>-A 12/26/12 BDDS report for an incident on 12/24/12 at 8:00am, indicated client #141 had an unknown abrasion injury to his left inner thigh. The report indicated the abrasion could have been "self inflicted" with long fingernails.</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  07/22/2013	
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>-A 12/26/12 BDDS report for an incident on 12/24/12 at 9:10am, indicated client #135 had an unknown bruise on her first toe on her right foot.</p> <p>-A 12/17/12 BDDS report for an incident on 12/14/12 at 4:15pm, indicated an unknown injury to client #96. The report indicated client #96 had "scratches" to his right upper arm and client #96's upper chest had a "small discolored" area.</p> <p>-A 12/3/12 report for an incident on 12/1/12 at 9:50pm, indicated client #20 had an unknown injury of a "fading bruise" brown in color measuring 3cm by 2cm on her left middle thigh that the CNA discovered during a shower.</p> <p>On 7/11/13 at 9:50am, an interview was conducted with Administrative (Admin.) Staff #2. Admin #2 indicated when staff discover an injury to a client they are to immediately report the identified injury to the Charge Nurse on their unit. Admin Staff #2 indicated the Charge Nurse documents the injury, files the incident report, and notifies the administration. Admin. Staff #2 indicated the administrative staff investigates the injury and files the BDDS report. Admin. Staff #2 indicated the administration should be notified immediately for all allegations</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  07/22/2013	
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>and all injuries. Admin Staff #2 indicated clients #20, #27, #73, #94, #96, #118, #135, and #141's injuries were not immediately reported to either the administrator and/or to BDDS in accordance with state law. Admin Staff #2 indicated client #141's financial exploitation of his pop money was not discovered until a separate incident for an allegation of abuse was being investigated.</p> <p>3. Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 7:20 AM and 7:45 AM. Client #76 was lying in her bed in her bedroom when LPN (Licensed Practical Nurse) #6 entered the client's bedroom to give client #76 her AM medications. Client #76 made verbal sounds. Client #76 had a hospital bracelet on her right wrist. LPN #6 was asked why client #76 had a hospital bracelet on and LPN #6 indicated the client was taken to the hospital on 7/8/13 to have staples removed from the back of her head due to an injury from a fall on 6/28/13. Client #76 had a quarter size hematoma on the back of her head. Client #76 turned her head toward the door, pointed toward the entrance door of her room and stated, "I fell." Client #76's abdomen was partially exposed with 2 greenish yellow bruises visible on her right lower quadrant of her</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  07/22/2013	
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>abdomen, one the size of a quarter and the other a nickel. LPN #6 stated "I didn't know she had those."</p> <p>During observations of the medication pass on the second floor of the facility on 7/9/13 between 7 AM and 8:35 AM the following was observed:</p> <p>__ Client #76 had 2 round greenish yellow bruises on her abdomen, one the size of a quarter and one the size of a nickel and an abrasion on her right wrist.</p> <p>__ Client #71 had a bruise on his lower left mid abdomen the size of a dime.</p> <p>Interview with LPN #6 on 7/9/13 at 8 AM indicated she did not know how client #76 received her injuries. LPN #6 stated client #71 "Probably received his bruise on his abdomen from the insulin injections."</p> <p>3.1-28(c)</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  07/22/2013	
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			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 4 of 91 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to fractures for clients #15, #16 and #55.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's reportable incident reports and/or investigations indicated the following for client #16:</p> <p>-11/27/12 Client was lying in bed and could not get up to take his medicine. Refused medication. Vitals-95.8 (temperature), 130/78 (blood pressure), 103 (pulse), 22 (respirations), 88% (room oxygen). Sent to [name of hospital] for evaluation."</p> <p>The undated ER/Hospital Report indicated "[Client #16] was transferred by nursing to [name of hospital] for evaluation and treatment due to change of</p>	W000154	<p>W154 I Client #16's ISP will be reviewed and updated as needed to include information regarding his specific seizure information (types, history). For clients #15, 16 and 55, the circumstances surrounding the fractures was investigated.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of documentation, staff interviews (from all 3 shifts if the fall/injury was not observed), and a conclusion including what is being done to help prevent reoccurrence.</p> <p>IV Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval.</p>	08/21/2013			

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 07/22/2013
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>condition. [Client #16] presented prior to PM meal with lethargy and change in mental status. [Client #16] refused to get up from bed for medications and PM meal. He appeared to be having difficulty sitting up in bed. Resident was admitted to [name of hospital] for observation of possible seizure activity and fever of unknown origin. Dilantin and Depakote (seizure medications) levels evaluated and dilantin (sic) level below therapeutic level. Chest X-ray normal. Ultrasound completed to L (left) lower extremity d/t (due to) edema no signs of DVT (Deep Vein Thrombosis). Resident returned from [name of hospital] on 11/30/12, however remained lethargic and complained of discomfort to both feet. Both lower extremities edematous. Resident returned to [name of hospital] 12/01/12 for further evaluation and treatment. He was re-admitted with fractures to L leg and both ankles. Resident underwent surgery to both ankle fractures...." The hospital report indicated client #16 was discharged to a rehabilitation facility from the hospital.</p> <p>-12/1/12 "Client's (client #16's) mental status has changed. He does not bear weight, will not eat, does not sit up without supportive assistance. Sent to [name of hospital] ER (emergency room) for evaluation.</p>		Corrections to be completed by August 21, 2013.		

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  07/22/2013
--	---	--	---

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>The facility's 12/7/12 follow-up report indicated "...A hole was found by staff in the wall in the bathroom in [client #16's] room while he was hospitalized between 11/27/12 and 11/30/12. [Client #16] was asked upon return on 11/30/12 if he had fallen in the bathroom, and he stated he had. [Client #16] continued to refuse to bear weight on 12/01/12 and displayed altered mental status. He was transferred to [name of hospital] ER..." The follow-up report indicated client #16 had multiple fractures of his left leg with both ankles broken.</p> <p>The facility's 12/14/12 follow-up report indicated it appeared client #16 received the multiple fractures from a fall in the bathroom as there was a hole in the wall. The follow-up report indicated client #16 had not experienced any falls in the past 6 months.</p> <p>The facility's undated Hospital/ER Report (12/1/12 admission) indicated client #16 was ambulatory. The hospital report indicated client #16's diagnoses included, but were not limited to, Epilepsy with recurrent seizures, Polydipsia (excessive drinking of water) and Osteoporosis. The undated report indicated at the 11/27/12 hospitalization, client #16 was diagnosed with Recurrent Seizure Disorder with</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  07/22/2013	
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>altered mental state secondary to postictal state (post seizure). The ER/hospital report indicated "...The hospital notes do indicate that they were aware that he had been unable to stand when he was sent out and that he had complained of leg pain in the hospital. They did an ultrasound to rule out clots and there is no indication that any other concerns regarding pain were identified while he was hospitalized..." The 12/12 hospital report and/or the 11/27/12 hospital report did not include a thorough investigation in regard to client #16's multiple fractures as the reports did not indicate who was interviewed, include any time lines, explain how client #16 fell, got up off the floor with multiple fractures, but could not get out of the bed. The facility's reports did not indicate/explain what kind of seizures client #16 experienced and/or indicate when he last had a seizure. The facility's reports did not indicate/include any medical consults on how the fractures may have occurred. The facility's reports failed to indicate if client #16 fell due to a seizure and/or had a seizure due to the multiple fractures/pain.</p> <p>Client #16's 11/30/12 Behavior Incident Report (BIR) indicated "[Client #16] had drank (sic) water &amp; (and) I asked him 11-30-12 if he fell prior to going to hospital &amp; he said yes- Fell to floor-asked</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  07/22/2013
--	---	--	---

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>how hole got in wall of bathroom, asked what body part caused the hole-[client #16] said he hit the wall with his back-[Client #16] said he did not hit his head."</p> <p>The facility's 11/30/12 hand written notes attached to the hospital reports indicated the facility did not ask client #16 how he got up off the floor and/or indicate if the client hit his legs on something. The reports also did not look at client to client incidents, and/or include interviews of clients or staff as only nursing staff were interviewed.</p> <p>Client #16's record was reviewed on 7/11/13 at 3:36 PM. Client #16's 11/30/12 Discharge Summary indicated "...The patient was admitted for evaluation and treatment of the altered mental status with the presumption being that he likely could have had an unwitnessed seizure and was having a postical (sic) episode..." The discharge summary indicated client #16 was seen by a neurologist who indicated "...they felt that the patient well could have had a seizure as an explanation for his symptoms. [Name of doctor] noted that the Dilantin level was low at 4.4 and it was still low at 5.9 and it was corrected for an albumin of 3.3...." The discharge summary indicated an Ultrasound was done of client #16's "left lower extremity and it was completely normal with no</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  07/22/2013
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>signs of DVT...."</p> <p>Interview with Program Director (PD) #1, administrative staff #2 and #3 on 7/12/13 at 11:49 PM indicated client #16 had been sent out to the hospital on 11/27/12 with a change in status and not wanting to walk. Administrative staff #2 indicated while the client was in the hospital the hole was found in the wall in the client's bathroom. Administrative staff #2 indicated when client #16 returned, he was asked how the hole occurred. Administrative staff #2, #3 and PD #1 indicated client #16 indicated he fell. Administrative staff #1 indicated the hospitalization from 11/27/12 indicated the client had a seizure. Administrative staff indicated the client most likely received multiple fractures to his leg and broke both his ankles when the client fell due to the seizure. Administrative staff #2 stated "Fall likely related from seizure. Fall not witnessed." When asked how client #16 got up off the floor with multiple fractures, PD #1 stated client #16 "probably got himself up off the floor." Administrative staff #2 indicated facility staff were interviewed, and no one assisted the client to get up off the floor. Administrative staff #2 also indicated client #16's roommate was interviewed and the roommate did not know how the hole in the bathroom occurred.</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  07/22/2013	
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>Administrative staff #2 indicated the facility conducted a thorough investigation in regard to client #16's fractures.</p> <p>2. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's 1/9/13 reportable incident report indicated on 1/7/13, client #15 was found on his knees in his bathroom with no signs of injury at that time. The 1/9/13 reportable incident report indicated "...There were no complaints or signs of pain or discomfort. Resident propels self in wheelchair but transfers independently. [Client #15] displayed no signs of discomfort and denied pain upon assessments."</p> <p>The facility's 1/25/13 follow-up report indicated client #15's fall was not witnessed and "...The precise cause of the fall was not identified..." The follow-up report indicated client #15 had " A displaced fracture of the right femur below the hip joint."</p> <p>The facility's undated Hospital/ER report indicated Conclusion: "[Client #15] was discharged from [name of hospital] to [name of facility] for rehabilitation. Prior</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  07/22/2013	
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>to [client #15's] return to North Willow, his team will meet to determine his current status and needs, update his care/risk plans and ISP accordingly, and train staff." The facility's undated hospital report/investigation/conclusion did not indicate how the client fractured his hip and/or indicate who was interviewed during the facility's investigation to ensure neglect and/or abuse did not occur.</p> <p>Interview with PD #1, administrative staff #2 and #3 on 7/12/13 at 11:49 AM indicated client #15 fell in the bathroom. Administrative staff #2 indicated an investigation was conducted but no investigation conclusion and/or recommendations were written up. Administrative staff #2 and #3 indicated the facility's template used for hospitalizations/fractures did not give them the information needed for conducting and/or documenting investigations of fractures.</p> <p>3. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's 12/23/12 reportable incident report indicated "[Client #55] was transferred to [name of hospital] ER for</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  07/22/2013
--	---	--	---

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>evaluation on 12/18/12 and returned with the diagnosis of gastritis on 12/21/12. He then returned to [name of hospital] ER for evaluation of left first finger d/t (due to) 1 cm (centimeter) yellow area as well as edema. Resident also noted at that time with edema to both lower extremities. Resident returned from [name of hospital] ER with diagnosis of folliculitis (hair follicle infection). Resident returned with new orders for antibiotic. Resident continued to present with edema to left forefinger and both feet and ankles. X-ray was obtained of left foot and ankle after presenting with bruising to area. X-ray 12/26/12 revealed a non-displaced fracture to left foot of the 2nd and 4th metatarsals (toes). No fracture or dislocation noted to the left ankle, however results show osteoarthritis of the left ankle...."</p> <p>The facility's 1/4/13 follow-up report indicated "There is no evidence of a fall. 23. The cause of the fracture is unknown at this time...."</p> <p>The facility's 1/14/13 follow-up report indicated client #55 saw an orthopedic specialist on 1/11/13. The follow-up report indicated client #55 had "...3 non-displaced fractures to L (left) foot. [Client #55] is to return to [name of orthopedic] 1/16/13 for follow up visit</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  07/22/2013	
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>after CT of left foot...He continues to wear soft cast (Cam boot) to left foot...."</p> <p>The facility's undated ER/Hospital Report (facility's summary of incident) indicated "...Conclusion: Resident is wearing a cast to left foot and leg at this time. Cast remains clean, dry and intact. Resident was seen by [name of orthopedist] on 1/11/13 and 1/16/13. He received a CT of L foot on 1/15/13. Orthopedic MD reports fracture is healing. Orders to remain non-weight bearing, but to transfer to toilet and to wheelchair. Resident is stable at this time with no complaints or signs of injury. Resident to return to [name of orthopedist] on 2/1/13. Resident has no history of falls, but has a new care plan for fractures." The facility's ER/Hospital Report indicated the facility did not conduct a thorough investigation in regard to client #55's fractures. The ER report did not indicate staff and/or clients were interviewed in regard to the client's fracture.</p> <p>Interview with PD #1, administrative staff #2 and #3 on 7/12/13 at 11:49 AM indicated client #55's hand injury was medical and not an injury of unknown source. Administrative staff #2 and #3 indicated there was no additional documentation of an investigation in regard to client #55's fracture/injury of</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  07/22/2013
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>unknown origin. Administrative staff #2 and #3 indicated the facility's template used for hospitalizations/fractures did not give them the information needed for conducting and/or documenting investigations of fractures.</p> <p>3.1-28(d)</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  07/22/2013	
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			
W000155	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on interview and record review for 1 of 91 allegations of abuse, neglect and/or exploitation reviewed, the facility failed to immediately suspend a professional staff in regard to an allegation of verbal abuse for client #141.</p> <p>Findings include:</p> <p>Confidential interview A indicated an allegation of abuse had been reported to the facility regarding a nurse and client #141 on 7/10/13.</p> <p>The facility's 7/10/13 reportable incident report indicated on 7/10/13 at 5:00 PM, "It was reported that [RN #8], RN, had referred to [client #141] using inappropriate language after [client #141] had hit her on the top of her head and spilled water/medications on her. It was confirmed the comment was said, but initial information is that it wasn't directed to [client #141]. Immediate corrective action was taken. [RN #8] was suspended today as well to allow for a thorough investigation of the incident...."</p> <p>Interview with administrative staff #2 on 7/11/13 at 10:17 AM indicated when asked if the facility had reported any</p>	W000155	<p>W155 I QA to review the agency's abuse/neglect policy and assure procedures are in place to prevent abuse, neglect and/or exploitation.</p> <p>Reinstated the flow chart: BIR/Fall Assessment - for resident 76's nurse to determine if need to call ED - BIR box for follow-up. THE DATE THE ED IS NOTIFIED IS TO BE INCLUDED ON THE COVER SHEET IN INVESTIGATION FILES. Late reports will be reviewed by the administrative team to develop corrective actions specific to the cause/individuals involved.</p> <p>Both individuals have been assessed by nursing and bruises observed at the time of the survey have resolved, however another bruise has been noted on resident 76 and is being investigated at this time.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Allegations of staff misconduct related to abuse, neglect or exploitation will be reviewed by at least 2 administrative/supervisory staff as a double check that immediate protective measures</p>	08/21/2013			

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  07/22/2013
--	---	--	---

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>allegations of abuse and/or neglect within the last 24 hours, administrative staff #2 stated "No, just with [client #98]."</p> <p>Interview with administrative staff #1 and #2 on 7/11/13 at 10:20 AM indicated no allegations of abuse had been reported to the administration from 7/10/13 to 7/11/13. When the surveyor went to report an allegation of abuse, administrative staff #1 indicated she was aware of an incident involving RN #8 and client #141. Administrative staff #1 indicated she and the Director of Nursing were told of the allegation on 7/10/13 by a Program Director. Administrative staff #1 indicated she (administrative staff #1) was told there were several people in the area when RN #8 made the comment about client #141. Administrative staff #1 indicated she was not sure if any other clients were present in the area when RN #8 made the statement to another staff person, but indicated other people were in the area. Administrative staff #1 stated "[RN #8's] statement about client #141 was "inappropriate." Administrative staff #1 indicated RN #8 admitted to making the statement. Administrative staff #1 indicated she did not see the statement as an allegation of verbal abuse. Administrative staff #1 indicated RN #8 was reprimanded on 7/10/13 for the statement. Administrative staff #1</p>		<p>are in place, that the Executive Director or designee has been notified as required, that an investigation has been initiated, and appropriate state reports filed.</p> <p>CNA and other support staff will be retrained on the abuse/neglect policy, including specific examples of verbal/emotional abuse.</p> <p>Administrative, supervisory and nursing staff are to be retrained on the abuse/neglect policy with ANY changes/revisions highlighted.</p> <p>Train nursing on which BIRs require immediate notification to the ED or designee. Retraining on abuse/neglect reporting will include the requirement the administrator be immediately notified.</p> <p>Staff have been trained that on day and evening shifts they are to assess each person they are serving with regard to the condition of their skin and report any issues no matter how small for assessment to assure any unknown issues are uncovered and reported for investigation.</p> <p>IV Client Advocates will assure process followed when there are cases of allegation of neglect and abuse with follow up with ED/DNS when any issues are noted. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC</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  07/22/2013
--	---	--	---

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
	indicated RN #1 was not suspended on 7/10/13 after the allegation was made.  3.1-28(d)		Director. Corrections to be completed by August 21, 2013.	

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  07/22/2013	
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			
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review, observation, and interview, the facility failed to assure 52 of 112 CNAs (Certified Nursing Aides) were trained in the detection of bedbug infestations for 15 of 15 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) and 133 additional clients (#16 through #148) living in the facility. The facility also failed to ensure nursing staff were re-trained to document all physical anomalies with client #28.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 7/11/13 at 3:30 P.M.. Review of a 7/11/13 incident report indicated there was an infestation of bedbugs in client #19's bedroom (room #103).</p> <p>Client #19's bedroom (room #103) was observed during the 7/12/13 observation period from 8:15 A.M. until 8:45 A.M.. The client's room was bolted shut as to not allow entrance to any clients or staff.</p>	W000189	<p>W189</p> <p>I For residents sited staff have been trained/retrained on bed bug identification and reporting. The nurse for resident 28 has been retrained to document anomalies that are present with the resident on their monthly skin assessment. Client Advocates will investigate all fractures.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Staff have been trained/retrained on bed bug identification and reporting. Nurses have been retrained to document anomalies that are present with the resident and to document on the monthly skin assessment. An investigation summary template to demonstrate thorough investigation of fractures has been developed. This format will clearly provide information regarding care/risk plans related to falls and/or fractures, a review of falls and follow-ups for the preceding 6 months, behavioral contributing factors, interview and observation of the individual and environment, a review of</p>	08/21/2013			

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  07/22/2013	
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>Maintenance Director #1 was interviewed on 7/12/13 at 8:46 A.M.. Maintenance director #1 indicated there was an infestation in client #19's bedroom. He further indicated that he had inspected adjacent rooms (Rooms #101 and #105) to assure those rooms had not been infested with bedbugs. When asked who inspects the remaining client rooms for all other clients, Maintenance Director #1 indicated the facility's CNAs inspect the remaining client rooms for possible bedbug infestations. He indicated the CNAs inspect the bedrooms daily when they make the client beds or change the clients' bed linen.</p> <p>CNAs #7, #8, #11, and #12 were interviewed on 7/12/13 at 8:57 A.M.. CNAs #7 and #8 indicated they had not been trained on the detection of bedbugs in client bedrooms. CNAs #11 and #12 indicated they had been trained on detecting bedbugs.</p> <p>The facility's records were further reviewed on 7/12/13 at 9:11 A.M.. Review of training records from 1/1/13 to 7/12/13 indicated 52 of 112 CNAs working in the facility had not been trained in the detection of bedbugs in clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15 and clients #16 through #148's bedrooms.</p>		<p>documentation, staff interviews (from all 3 shifts if the fall/injury was not observed), and a conclusion including what is being done to help prevent reoccurrence.</p> <p>IV Director of Clinical Education has been provided with the information to train staff in orientation on bed bug identification and reporting and this has begun. Unknown fractures have a final review by the HRC Director who reviews information with the ED/DNS for final approval. DCE/DNS/ADNS/Designee will audit charts for monthly skin assessment completion and filing. Corrections to be completed by August 21, 2013.</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  07/22/2013	
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>Program Director #1 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #1 indicated the facility's CNAs were to look for signs of bedbug infestation while they make the client beds or change the clients' bed linen. Program Director #1 further indicated 52 of 112 of the facility's CNAs had not been trained on the detection of bedbug infestations in client bedrooms.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's 5/22/13 reportable incident report indicated "[Client #28] was being seen by his neurologist and the neurologist noted a bump on [client #28's] right forearm. He asked if [client #28] had an earlier fracture and then stated it could be something else, such as a tumor. An Xray was done to rule out disease or fracture in-house by [name of x-ray company] on 5-22-13. The results of the xray were not definitive...Results: Bony abnormal midshaft of ulna probably due to fracture with bony delayed union. Correlation with patient's history recommended. Careful follow-up is recommended. Remainder of exam unremarkable. Conclusion: Probably delayed union of fracture. Other etiologies cannot be</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  07/22/2013
--	---	--	---

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>excluded in correlation with clinical history and continued careful radiographic follow-up and if indicated orthopedic consult recommended..." The 5/22/13 indicated client #28 was taken to a orthopedic "walk-in clinic" but no doctor was available to see the client. The reportable incident report indicated an appointment was made for 5/23/13. The 5/22/13 reportable incident report indicated client #28's diagnosis included, but was not limited to, "Kugelberg-Welander Disease, a progressive spinal muscular atrophy."</p> <p>The facility's 5/28/13 follow-up report indicated the Bureau of Developmental Disabilities Services (BDDS) had requested more information in regard to client #28's fracture. The 5/28/13 follow-up report indicated "...They (orthopedist) confirmed an old non-union fracture of his right ulna. His arm was casted (splint) and he has a follow-up appointment on 5/31. 2. Has it been determined what the lump is and the cause of it?- The lump is bone calcification from the fracture. 3. Has anyone on his team or medical staff noticed this prior to the apt (appointment) with the neurologist?- Yes, when staff were interviewed, several indicated that [client #28's] arms have always appeared to have anomalies and with weight loss it</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  07/22/2013
--	---	--	---

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>may be more apparent. Nobody associated the bump with any type of injury or discomfort. When this writer talked to [client #28], he said his arm doesn't hurt. He couldn't answer if he remembered ever injuring his arm. His guardian was also asked and did not know of any old injuries, but added that [client #28's] late father had handled health issues in the past. At some point in the past, [client #28] suffered a non-union fracture to his right ulna. At this point, no time frame has been established to determine when that fracture occurred, though information provided by [name of orthopedist] indicates it is old...." The follow-up report indicated client #28's fracture could be ten or more years old. The follow-up report indicated "...6. Has a possible cause of the fracture been determined? -No- a particular, specific cause was not identified. Over the course of a decade or more, he has had falls, behavioral incidents, etc. that could potentially lead to injury, but nothing that clearly relates to his old fracture. 7. What is in place to prevent future fractures?- As part of client-specific-training. [Client #28's] staff have been trained on his transfers. His bed is kept in the low position, he has a fall mat, bed rails, a padded lap tray, padding on his walls, and he is regularly repositioned by staff. 8. What is in place</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  07/22/2013	
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>to ensure that future 'anomalies' are checked out by a medical professional when noted by staff?- Staff are trained to notify nursing of any changes in status - but it should be noted that the staff who had previously noted the lump also said it had been there for a long time- it wasn't a change. 9. Is there a concern that staff has noted this lump previously but it wasn't examined further until the neurologist noted it? The need to have readily available documentation of scars, lumps, body anomalies, etc., was identified. Nursing will be trained to note any such observations on quarterly and annual body assessments...." The 5/22/13 reportable incident report and/or 5/28/13 follow-up report did not indicate the facility's nursing staff had been trained to document clients' anomalies.</p> <p>Interview with Program Director (PD) #1, administrative staff #2 and #3 on 7/12/13 at 11:49 PM indicated client #28 had an old fracture. PD #1, administrative staff #1 and #2 indicated the nursing staff should have documented the anomaly/lump on client #28's arm in the client's record. PD #1 indicated the Assistant Director of Nursing (ADON) did the training. As of 7/12/13, the facility did not provide evidence nursing staff were trained to document anomalies of clients.</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  07/22/2013
--	---	--	---

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
	3.1-13(b)(1) 3.1-13(b)(2) 2-7-3(a)			

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  07/22/2013	
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			
W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview, and record review for 2 of 15 sampled clients (#1 and #9) and 6 additional clients (#23, #25, #63, #65, #72 and #76), the facility failed to ensure the Interdisciplinary Team (IDT) assessed/re-assessed:            ___ Client #76 in regard to her ambulatory needs.            ___ Clients #1, #9, #23, #25, #63, #65 and #72 in regard to the facility practice of having clients sit on the hooyer slings after being transferred into a chair/wheelchair.</p> <p>Findings include:</p> <p>1. A facility BDDS (Bureau of Developmental Disabilities Services) report of 7/12/13 at 9:56 AM reviewed on 7/12/13 at 1 PM indicated on 7/11/13 at 7:15 AM "[Client #76] fell in the bathroom, receiving a 'v' shaped laceration (3 cm x 3 cm) (centimeter) to her forehead and a cut to the bridge of her nose. Steri strips were applied in house. Vitals were taken with her blood pressure reading 195/133, temp 96.2 and O2 saturation 98%. Her physician was</p>	W000210	<p>W210 I For resident Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT.Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid. For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other, injury are specified.. Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on</p>	08/21/2013			

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  07/22/2013
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>contacted and did not order her to be sent out. Due to concerns related to a prior fall with injury to the back of her head (previously reported), [client #76] was sent to [name of hospital] ER. [Client #76] returned yesterday evening with new diagnosis of closed head injury, and facial laceration."</p> <p>Review of the facility falls reports from April 2013 through July 2013 on 7/9/13 at 9 AM indicated:            ___ On 4/18/13 client #76 walked away from her walker to throw some trash away and fell to her buttocks. No injury was reported.            ___ On 6/6/13 at 7:20 PM client #76 tripped on a chair and fell, hitting her head on another chair as she went down. The report indicated client #76 obtained a small laceration to the bridge of her nose and a bump on her forehead.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 7:20 AM and 7:45 AM. Client #76 was lying in her bed in her bedroom when LPN (Licensed Practical Nurse) #6 entered the client's bedroom to give client #76 her AM medications. Client #76 made verbal sounds. Client #76 had a hospital bracelet on her right wrist. LPN #6 was asked why client #76 had a hospital bracelet on and LPN #6</p>		<p>identification and reporting of abuse and neglect.            Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.            Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift.            Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</p> <p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</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  07/22/2013	
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>indicated the client was taken to the hospital on 7/8/13 to have staples removed from the back of her head due to an injury from a fall on 6/28/13. Client #76 had a quarter size hematoma on the back of her head. Client #76 turned her head toward the door, pointed toward the entrance door of her room and stated, "I fell." Client #76's abdomen was partially exposed with 2 greenish yellow bruises visible on her right lower quadrant of her abdomen, one the size of a quarter and the other a nickel. LPN #6 stated "I didn't know she had those."</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 9:45 AM through 10:00 AM. At 9:45 AM client #76 was seated in a chair facing the North window of her bedroom. There were no facility staff in client #76's bedroom at 9:45 AM. Client #76 had a half-dollar, red, raised area located to left/center of her forehead above her left eyebrow. Client #76's raised area was covered with two steri strips which were saturated with dark red to black fluid. Client #76's forehead and hairline had dried dark red to black fluid. Client #76's index, middle, ring finger and thumb nails had dried dark red to black fluid under the fingernails. Client #76's left temple area was swollen, dark red to black in color. The bridge of client #76's</p>		<p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan.</p> <p>QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>All falls will be documented using the Outreach Services fall form. Clients will be placed on 15 minute checks until the IDT can meet. Client will be referred to PT for a screen/evaluation. Any changes made to the client's fall plan will be inserviced and client specific training will be updated. Nursing has been inserviced on completion of neruo checks and protocol for sending out clients</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  07/22/2013
--	---	--	---

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>nose, between her eyes, was swollen and colored dark red to black. At 9:50 AM CNA (Certified Nurse Aide) #1 entered client #76's bedroom. CNA #1 directed client #76 to use her walker and come to the unit program room. CNA #1 and client #76 exited the bedroom and the client walked to the unit program room without physical assistance or physical prompts from CNA #1. Client #76 then returned to her bedroom. Client #76's forehead was wiped with a wet tissue. Client #76's steri strips were not changed or cleaned.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 10:50 AM through 12:05 PM. At 10:50 AM client #76 was seated in a chair in the classroom. The client had a large hematoma (swollen area) the size of a quarter above her left brow near her nose. The hematoma had two steri-strips that were saturated with dried blood with a small amount of fresh blood oozing around the steri-strips. Client #76 had blood smeared on her forehead, across the bridge of her nose and on her fingers and one steri-strip across the bridge of her nose as well as abrasions above and around her left eye with noted bruising. CNA #1 was sitting at the table nearby client #76 and was asked what was on client #76's face. CNA #1 stated "That's</p>		<p>who have sustained a head injury.</p> <p>For clients #1, #9, #23, #25, #63, #65 and #72 contact vendor to complete training on slings. Identify the appropriate size sling (and color). Include above information on the assignment sheet and in client specific training. Nursing services to complete a care plan regarding sling usage for these clients.</p> <p>Team will complete an IDT. Staff will be inserviced on above.</p> <p>All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Include above information on the assignment sheet and in client specific training. Nursing services to complete a care plan regarding sling usage for these clients with regard to sling usage.</p> <p>Team will complete an IDT. Staff will be inserviced on sling usage. CNA and other support staff will be retrained on the falls procedure including where fall risk information is maintained and</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 07/22/2013	
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			
	blood where she fell and she keeps scratching at herself." CNA #1 put on gloves and attempted to wipe client #76's forehead with a disposable hand towelette. Client #76 pushed CNA #1 away while making crying sounds. CNA #1 stated, "Oh, she always does that when I touch her face. She don't like anybody touching her." CNA #1 was asked if client #76 had been offered an ice pack. CNA #1 stated, "No, no one has said anything about her using an icepack and I haven't seen her with one." The CNA indicated she had not been given any instructions from the LPN to offer client #76 an icepack. At 10:55 AM client #76 got up from her chair and walked to the bathroom in the activity room. Client #76 walked with an unsteady gait using a rolling walker. Client #76 set her walker outside of the bathroom and proceeded to go into the bathroom by herself. CNA #1 stated, "See, she always does that. We can't get her to use her walker and then she falls." CNA #1 opened the bathroom door to assist client #76. Client #76 had urinated on her clothing while in the bathroom and walked to her bedroom, using her walker and unassisted by the staff. CNA #1 followed client #76 to her bedroom and assisted client #76 to change her clothes. At 11:05 AM, after changing clothes, client #76 walked back to the classroom, again unassisted by the staff		what follow-up expectations are in place. For those individuals with a history of multiple falls or falls with significant injury (requiring more than in-house 1st aid), the IDTs will meet to review existing care (risk) plans to assure they are current, reflect most recent PT/professional recommendations and clarify expectations during the period following the fall and prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. Revised fall procedure to be educated with staff. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid. Staff have been retrained on identification and reporting of abuse and neglect.  Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed. Nursing staff have been trained.  A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.				

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  07/22/2013	
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			
	and sat in one of the chairs near the window. CNA #1 was asked if client #76 was able to communicate and to express when she was in pain. CNA #1 stated "For the most part, she can let you know when she's hurting, but not always." Client #76 was asked if she hurt or was in pain. Client #76 moved her head up and down and in a circular motion while smiling. Client #76 still had blood smeared on her forehead and across the bridge of her nose. CNA #1 again attempted to wipe client #76's forehead with a disposable towelette and the client pushed the staff away making a crying noise. A spot of blood was noted on client #76's right leg of her sweat pants that she was wearing. CNA #1 stated the spot on client #76's clothing was blood from the client's forehead. CNA #1 was asked if she had reported the continued oozing of blood from the injury to the nurse. CNA #1 stated, "No." CNA #1 indicated the nurse and/or the QIDP (Qualified Intellectual Disabilities Professional) had not given the staff any specific guidance of how to supervise and/or assist client #76 in regard to falls. At 11:35 AM LPN (Licensed Practical Nurse) #1 approached client #76 and asked the client, "Hey, you alright?" Client #76 did not respond and the nurse left the classroom and returned with a small cup of water and offered it to client #76. Client #76 pushed LPN #1's		Nursing has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.  Nursing staff have been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion.  The fall assessment will be used by the IDT to assist in development or revision of the fall prevention/safe ambulation plan when needed. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. Administrative, supervisory and nursing staff are to be retrained on the reviewed/revised abuse/neglect policy with ANY changes/revisions highlighted. QMRP staff will observe prescribed use of sling when completing the transfer observations with those residents who use slings.  IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question				

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  07/22/2013	
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>hand away and refused the water. LPN #1 stated, "OK" and left the room. Client #76 began rubbing her forehead and left eye.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 2:40 PM through 2:45 PM. Client #76 was laying asleep in her bed. No changes were noted in the steri-strips. Client #76's face presented with streaks of dried blood across her forehead, nose and left eye. More bruising was noted around the orbit of her left eye. The steri strip across the bridge of her nose was in place. Client #76's nose was crooked and appeared more swollen than when observed earlier in the day.</p> <p>Client #76's record was reviewed on 7/11/13 at 1 PM. Client #76's nursing notes indicated:            ___ On 4/18/13 the client took a few steps toward the trash can to throw trash away without the use of her walker and lost her balance and fell onto her buttocks.            ___ On 6/28/13 client #76 lost her balance as she was walking towards her room with her walker and fell backwards hitting the back of her head on the corner of the door frame. "Resident had cut and bump that was bleeding to back of head upon assessment. BP (Blood Pressure) 167/95, P (Pulse) 88 R (Respirations) 18. O2 (blood oxygen level) 98% on room air.</p>		<p>as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. Active Treatment audits completed by QMRPs and transfer observations will include proper sling use. Corrections to be completed by August 21, 2013.</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  07/22/2013
--	---	--	---

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>Resident cried momentarily but was still alert and oriented. Resident sent to ER (Emergency Room) and came back with staples to back of head."</p> <p>__ On 6/29/13 "Client rested through the night. Noted with 4 staples upper left back of head, dry intact, no s/s (signs and/or symptoms) of infx (infection). At 2 AM BP 162/64, P-81, R-18... Neuro checks wnl (within normal limits)."</p> <p>__ On 7/8/13 the staples to the back of the client's head were removed.</p> <p>__ On 7/10/13 a floor mat for fall prevention was removed.</p> <p>__ On 7/11/13 at 9:55 AM, at 7:15 AM, "Client fall occurred today at 7:15 am while ambulating with walker to the bathroom stumbled and fell face first. Has an area raised to forehead open area small v shape gash measuring 3 cm x 3 cm on each side. And skin tear to bridge of nose. Steri strips applied to forehead and bridge of nose. Tylenol admin (administered) as ordered for discomfort. V/S (vital signs): 96.2 [temperature], 195/133 [blood pressure], 19 [respirations], O2 98 [Oxygen Saturation in the blood]."</p> <p>"[Name of doctor] informed, family notified and DON (Director of Nursing)/ED (Executive Director) made aware of client status."</p> <p>Client #76's risk plan of 10/12/12 for falls indicated client #76 is "At risk for injury</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  07/22/2013	
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>from falls or mobility trauma related to possible bone marrow suppression as a result of hypocalcemia as side effect of Depakote." The plan indicated the staff were to encourage client #76 to slow down when walking, wear proper fitting shoes and to be aware of her surroundings. The plan indicated the staff were to encourage client #76 to use her walker and to pay attention to her surroundings when ambulating and the staff were to provide stand by assistance while exercising. Client #76's risk plan indicated no revisions or updates due to the client's recent falls in April, June and July.</p> <p>Client #76's ISP (Individualized Support Plan) of 11/1/12 indicated client #76 ambulated with independence via a wheeled walker and was at risk for falls. The ISP indicated a physical therapist saw client #76 on 10/30/12 which "revealed [client #76] tends to forget her forward wheeling walker and ambulates to short distances. Needs supervision for toileting and maximum verbal cues to use her walker."</p> <p>Client #76's IDT (Interdisciplinary Team) notes indicated: __ On 4/26/13 the IDT reviewed client #76's fall on 4/18/13 when she lost her balance as she was taking her dinner plate</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 07/22/2013	
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>to the cart. No specific changes were made to her plan of care.</p> <p>__ On 6/12/13 the IDT reviewed client #76's fall in the dining room during church service on 6/7/13. The staff reported client #76 was walking and tripped on a chair and fell, hitting her head on another chair and sustaining a small cut on the bridge of her nose and a bump on her forehead. The team indicated it was an accident and the staff were directed to ensure that any tripping hazard that might impede safe movement of the client be removed.</p> <p>__ On 7/9/13 IDT notes indicated client #76 was sent to the hospital ER on 6/28/13 due to a fall she had in her bedroom. Client #76 was walking with her walker into her bedroom when she fell as she turned around hitting her head on the door frame resulting in lacerations to the back of her head. As a result, the client was treated and released with staples to the laceration. The IDT made no further recommendations and/or changes to the client's plan of treatment/care.</p> <p>Client #76's ISP/record did not indicate any revisions by the IDT (Interdisciplinary Team) due to client #76's falls in April, June and July to ensure client #76's safety due to falls with injury.</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  07/22/2013
--	---	--	---

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>Client #76 was interviewed on 7/11/13 at 9:45 AM. When asked how she injured her head, client #76 stated, "... fell."</p> <p>During interview with CNA #12 on 7/11/13 at 11:20 AM in the 2 West classroom where client #76 was sitting, CNA #12 was asked how the staff were to supervise and/or monitor client #76 and had there been any recent changes/directions and/or training in regard to client #76 in regard to her falls and head injury. CNA #12 stated, "Oh, I don't know. She's not my person." At the time of the interview CNA #1 had stepped out of the room to assist with another client and CNA #12 was alone in the classroom with client #76 and 4 other clients.</p> <p>Interview with CNA #1 on 7/11/13 at 11:50 AM indicated nursing staff and/or programming staff had not provided or informed the direct care staff in any changes in client #76's care and/or in the level of supervision the staff were to provide client #76 to ensure her safety due to recurrent falls.</p> <p>CNA #1 was interviewed on 7/11/13 at 2:41 PM. CNA #1 stated, "I was working with [client #76] this morning when she fell. I was standing at [client #76's] bed</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  07/22/2013	
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>while she was using her walker to go to the restroom. I looked up and [client #76] was laying with her face on the floor in front of her restroom. There was blood splattered on the walls and all over the floor." CNA #1 stated, "I saw the amount of blood. So, I called the other CNA, [CNA #2], and the nurse, [LPN (Licensed Practical Nurse) #1]. [CNA #2] came and helped me get [client #76] up. [LPN #1] came in and helped look at [client #76]." When asked if LPN #1 had given her any instructions regarding how to monitor client #76's head injury, CNA #1 stated, "No, no one gave us any instructions." CNA #1 indicated client #76 was asleep in her bed. CNA #1 stated, "[Client #76] laid down around 1:15 PM. [Client #76] just fell asleep about 20 minutes ago."</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1 and PD (Program Director) #3 on 7/11/13 at 5:25 PM indicated there had been no specific changes made to client #76's ISP in regard to client #76's falls and/or how the staff were to supervise and/or monitor client #76 to protect client #76 from recurring injury due to falls. The PD #3 indicated the client was last assessed by PT (Physical Therapy) on 10/30/12. The PD #3 stated "I was going to have her reassessed after this last fall with injury." When asked why the client was not</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  07/22/2013
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>reassessed after the fall with injury in June, the PD indicated the client should have been seen by PT and was not sure why she wasn't.</p> <p>2. Observations were conducted on the West wing of the 2nd floor of the facility on 7/8/13 between 3:15 PM and 5:45 PM and again on 7/9/13 between 6:10 AM and 8:20 AM. During both observation periods, clients #9, #63, #65 and #72 were observed sitting in wheelchairs. The clients sat on the hooyer lift slings while in their wheel chairs. Client #9 was sitting on a 5 inch pressure relief cushion also with the sling under her.</p> <p>Client #9's record was reviewed on 7/12/13 at 3 PM. Client #9's IDT (Interdisciplinary Team) of 5/21/13 indicated "Following [client #9's] two unknown injuries this month. On May 8th [client #9] was reported with a fading bruise to her left side flank, and on May 23rd she had a skin tear to outer left lower leg. At this time team feels that the first injury was most likely caused by the sling used for her transfers...."</p> <p>Interview with the ADON (Assistant Director of Nurses) on 7/12/13 at 2 PM stated the slings were "typically" left under the clients. The ADON indicated it would be difficult to move the clients</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  07/22/2013	
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>without the sling already in position under the clients.</p> <p>Telephone interview with PD #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM indicated it was a facility practice to leave the hoyer sling under the clients when positioning them in their wheelchairs. PD #3 indicated client #9 had a history of shoulder dislocations and trying to put the sling under her while sitting in her wheel chair could be dangerous. QIDP #1 indicated client #9 was assessed by OT (Occupational Therapist) to need a pressure relief cushion while sitting in her wheel chair. When asked if leaving the sling under clients would impede the use of pressure relief cushions and/or supports to prevent pressure ulcers, the PD #3 stated, "I really don't know. I think that is something we may need to revisit and re-assess on an individual basis."</p> <p>3. Observations were conducted on the first level of the facility on 7/8/13 from 1:00 P.M. until 2:00 P.M. and again from 2:30 P.M. until 6:25 P.M.. During both observation periods, clients #1, #23 and #25 were sitting on blue Hoyer lift slings while seated in their wheelchairs.</p> <p>An observation was conducted on the first level of the facility on 7/9/13 from 6:20</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  07/22/2013
--	---	--	---

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>A.M. until 9:30 A.M.. From 7:08 A.M. until 9:30, clients #1, #23 and #25 sat on blue Hoyer lift slings while sitting in their wheelchairs. The slings were bunched up behind their backs and underneath their legs.</p> <p>A review of the facility's undated Lift manual was conducted on 7/10/13 at 12:00 P.M.. Review of the lift manual indicated: "Unclip the sling attachment clips...Remove the lift, making sure the patient's feet and body are clear of the lift...Remove the sling form (sic) the patient." The staff training check off list indicated: "Lower resident while maintaining pressure on tilting frame to obtain correct positioning of individual in chair or bed...Unclasp clips from chassis...Move lift away making sure resident's feet and body are clear of lift...Remove wings of sling out from under and between legs...Grasp sling at both sides, shoulder level with a gentle pull, remove sling from a lying down position, roll the resident to remove sling."</p> <p>An interview with the Director of Nursing (DON) was conducted on 7/12/13 at 1:30 P.M.. The DON indicated although she has seen clients sitting on the blue Hoyer lift sling, clients should not sit on Hoyer lift slings while sitting in their</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  07/22/2013
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	
	wheelchairs. The DON further indicated all staff are trained on the use of the Hoyer lift and removing the slings after transferring clients from one place to another.  3.1-31(a)				

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  07/22/2013	
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			
W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based upon observation, record review, and interview for 2 of 15 sampled clients (clients #5, and #6) the facility failed to ensure address client #5's barriers to live in a less restrictive environment, and to address client #6's behavior of lifting her shirt.</p> <p>Findings included:</p> <p>1. Observations were completed at the facility on 7/8/13 from 3:25 PM until 6:25 PM. At 4:10 PM, client #5 indicated she wanted to move into a more independent supported living environment in the community and stated, "I hate it here, I'm too high functioning." She indicated she was unsure if she was on the waiting list for more independent living.</p> <p>Client #5's record was reviewed on 7/11/13 at 8:44 AM. Her 1/10/13 Individual Support Plan (ISP) included objectives to plan a meal, participate weekly in exercises, identify side effects of medication, sign in and out of work, follow diet, write check for "bills, keep</p>	W000227	<p>W227 I Corrective Action for Cited Clients includes: Easter Seals Crossroads has been contacted to assist in initiating a vocational program for client #5. Client #5's FSA, Vocational Assessment, and Formal Goals have been reviewed and revised to more appropriately address barriers preventing her from moving to a less-restrictive living environment. Additionally, Client #5's Legal Guardian has been approached to meet and discuss on an ongoing basis, the potential for her to explore other placements in the future. Client #6's Behavior Support Plan has been revised to include the behavior of exposing herself. Client #6's dressing goal has been reviewed and retrained with staff.</p> <p>II All residents might be at risk for this deficient practice.</p> <p>III IDT's have reviewed placement appropriateness and outlined any steps towards alternate placement as needed. QMRP's have been retrained that any maladaptive behavior that occurs more than 3 times in a</p>	08/21/2013			

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  07/22/2013
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	
	her room clean." In the area of vocational services, client #5 was noted as not being "appropriate" for community employment. A vocational assessment dated 1/10/13 did not indicate barriers to client #5's goal to have a community based job. There was no evidence of why client #5 was not appropriate for community employment, or was there evidence of referral for community employment. An IDT (interdisciplinary) note dated 7/13/12 indicated discussion regarding a "job coach and assisted living." There was no documentation of the results of the IDT discussion in client #5's record regarding community employment or assisted living. Her 9/4/12 Functional Skills Assessment indicated she could not make change or shop for herself, but was independent in all other area of shopping skills, could not identify cleaning supplies, or use them safely, but was independent in all other areas of housekeeping, could not identify her address, but was independent in all other areas of self awareness, could not count or match coins, could not identify or count bills, write checks or balance a check book, but was independent in all other areas of money management. Client #5 was independent in gross motor skills, laundry skills, cooking skills, identification skills, survival skills, communication skills, cognitive/academic		thirty-day period must be formally incorporated into the resident's plan and trained with staff.  IV Program Directors review ISPs, IDTs and assessments to assure accuracy and completeness. Appropriateness of placement will also be discussed at each resident's Quarterly Review. Corrections to be completed by August 21, 2013.		

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  07/22/2013	
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>skills, social skills, personal hygiene and grooming, dressing, meal time, toileting, and bathing skills. A 1/10/13 Behavior Support Plan (BSP) indicated target behaviors of agitation (undefined) and self injurious behavior (undefined). Behavior rates for agitation were 34 and self injurious behavior was 0 for the months of 9/12-11/12. Behavior rates for agitation were 43 and 0 for self injurious behavior for the months of 12/12-2/13. Behavior rates for agitation were 3 and self injurious behavior was 0 for the months of 4/13-6/13. A psychiatrist consult and follow-up form dated 7/9/13 indicated for psychiatric impression/assessment: Targeted behaviors below baseline. Team requests no med revision at this time...No complaints. No S.E. (side effects) noted." Client #5's vocational assessment dated 1/10/13 indicated client #5 had a goal to go to work daily and did not indicate she had behaviors in the workshop.</p> <p>Client #5 was interviewed on 7/12/13 at 10:55 AM. She stated she "would love to be referred to vocational rehab." She indicated she used to have a community based job in her previous living settings, but did not have a job here. She indicated her legal guardian had stopped looking at alternate placement for her after a last placement failed due to difficulty walking</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  07/22/2013	
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>up a stairwell without a handrail.</p> <p>Program Director (PD) #1 and QIDP (Qualified Intellectual Disabilities Professional) #3 were interviewed on 7/12/13 at 12:40 PM. PD #1 indicated they were aware of client #5's desire to live in a more independent environment, but client #5's legal guardian was opposed to client #5 living in the community due to a history of failed placements. They indicated client #5 had exhibited physical behaviors in the past which caused her return to her current living setting. They indicated client #5 did not exhibit the behavior currently. When asked about steps the facility had taken to support client #5 in her desire to live independently, they indicated they had encouraged client #5 to discuss her desire for independence to a self advocate group. They stated client #5 worked "full time" at workshop one hour daily Monday through Friday, and client #5 was not referred to vocational rehabilitation to their knowledge.</p> <p>Client #5 was observed while at workshop on 7/12/13 from 2:00 PM until 2:20 PM. Client #5 worked independently taking CDs (compact discs) from packaging.</p> <p>The workshop supervisor was interviewed</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  07/22/2013	
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>on 7/12/13 at 2:05 PM. She indicated client #5 worked independently and had work skills sufficient for community employment. She indicated client #5 had a job previously in the community. She indicated client #5 was not able to work longer than one hour daily due to behaviors of the group she attended with and the CNA who accompanied the clients had to leave her shift at 2:30 PM.</p> <p>2. Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #6 was seated at the table. Client #6 was wearing a top which was covering her gait belt. At 3:31 P.M. client #6 pulled her top up exposing her abdomen and breast. No redirection was given for her to put her top down. Client #6 put her hands under her top, pulling her top up to her mouth exposing her abdomen and breast(s) seven more times during the observation period at 4:04 P.M., 4:12 P.M., 4:37 P.M., 4:44 P.M., 4:55 P.M. 5:03 P.M. and 5:14 P.M. Certified Nursing Aide (CNA)s #70, #71 and #72 were located in the classroom during the observation time period. CNA #72 verbally prompted client #6 to put her shirt down at 4:14 P.M. and 4:42 P.M. CNA #71 physically assisted client #6 with putting her shirt down at 5:12 P.M.</p> <p>Observations of the second floor north</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  07/22/2013	
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>class room were conducted on 7/12/13 from 8:48 A.M. until 9:25 A.M. Client #6 was in the classroom wearing a top without an under garment under the top. Client #6 lifted her top to her mouth exposing herself. There was no redirection from staff. On 7/12/13 at 9:19 A.M. CNA #73 was asked if client #6 was to be wearing a tank top under her shirt, CNA #73 stated, "Oh yes." CNA #73 then verbally prompted client #6 to put her top down. CNA #73 got a tank top for client #6, assisting client #6 into the restroom. Client #6 exited the restroom with a tank top under her top and a gait belt on the outside of both shirts. CNA #73 stated, "She will not wear a bra, and she gets a cream applied, we were waiting to apply the cream, but forgot to put her tank top on."</p> <p>Client #6's record was reviewed on 7/11/13 at 1:50 P.M. Client #6's Individual Support Plan (ISP) dated 9/13/12 included a goal for client #6 to "Put on a tank top under shirt." Client #6's record did not indicate a plan to address client #6's behavior of exposing herself by lifting up her top.</p> <p>An interview was conducted with QIDP #2 on 7/12/13 at 12:09 P.M. When asked about client #6 lifting up her shirt, QIDP #2 stated, "Staff should have prompted</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  07/22/2013
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>her to put her shirt down."</p> <p>An interview was conducted with the Program Director (PD) #3 on 7/12/13 at 12:10 P.M. When asked what staff are to do when client #6 lifts her shirt, PD #3 stated, "She has a goal to wear a tank top under her top. Staff should prompt her to pull her shirt down." When asked about a goal for client #6 to keep her shirt down, PD #3 stated, "She doesn't have a formal goal, we teach things to not do in public. She does it a lot. She needs constant redirection to not pull shirt up." PD #3 indicated client #6 did have an identified need to not expose herself in public.</p> <p>3.1-35 (a) 3.1-35(b)(1)</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  07/22/2013
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	
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4) and for 6 additional clients (clients #23, #24, #27, #28, #30 and #132), the clients' Individual Support plans (ISPs) failed to include guidelines on how and when staff were to position the clients in and out of their wheelchairs and beds, to specifically indicate how a client was to be monitored/supervised in her bedroom when awake, and to indicate when a client should be encouraged to elevate her legs.</p> <p>Findings include:</p> <p>1. Observations were conducted on 7/8/13 from 1:00 P.M. until 2:00 P.M. and from 2:30 P.M. until 6:25 P.M.. During the entire observation period clients #1, #4, #23, #27, #28 and #30 were observed sitting in their wheelchairs. During the entire observation period client #3 lay on his back in his bed.</p> <p>An observation was conducted on 7/9/13 from 6:20 A.M. until 9:30 P.M.. During the entire observation period client #3 lay on his back in his bed. From 7:00 A.M.</p>	W000240	<p>W240I For residents 4, 23, 27, 28, and 30 staff have been retrained to document on the back of the 24hr flow sheet when a client has been repositioned and what position they have been moved to. (if in bed) 24 hour flow sheet has been revised in order to document repositioning when client is in wheelchair. PT/OT will complete assessments on repositioning Client specific training has been revised to include this information/in service staff on appropriate positioning. Include appropriate transfer status. For resident 132 housekeeping staff has been inserviced to not enter a clients room to clean/mop when the client is in the room and to not block entrance of client bedrooms with the cleaning carts. Client #24 will have a schedule for elevating her legs developed and a chart for documentation created. If she continues to refuse, then the IDT will address or add a targeted behavior to her BSP. Staff will also provide education to client #24 if she refuses to elevate her legs on the health issues related to her refusal. II All residents of North Willow have the potential to be harmed by the deficient practice. III Staff have been retrained to</p>	08/21/2013	

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  07/22/2013	
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>until 9:30 A.M., clients #1, #4, #23, #27, #28 and #30 were observed sitting in their wheelchairs.</p> <p>A review of client #1's record was conducted on 7/11/13 at 9:30 A.M.. The Individual Support Plan (ISP) dated 8/14/12 did not indicate guidelines on how and when staff were to assist the client in positioning himself in and out of the wheelchair.</p> <p>A review of client #4's record was conducted on 7/11/13 at 11:50 A.M.. A review of client #4's ISP dated 3/19/13 did not indicate guidelines on how and when staff were to assist the client in positioning himself in and out of the wheelchair and when lying in bed.</p> <p>A review of client #3's record was conducted on 7/11/13 at 2:00 P.M.. The ISP dated 1/31/13 did not indicate guidelines on how and when staff were to assist the client in positioning herself in and out of the wheelchair.</p> <p>A review of client #23's record was conducted on 7/12/13 at 8:55 A.M.. The ISP dated 12/4/12 did not indicate guidelines on how and when staff were to assist the client in positioning herself in and out of the wheelchair.</p>		<p>document on the back of the 24hr flow sheet when a client has been repositioned and what position they have been moved to. (if in bed) 24 hour flow sheet has been revised in order to document repositioning when client is in wheelchair. PT/OT will complete assessments on repositioning Client specific training has been revised to include this information/in-service staff on appropriate positioning. Include appropriate transfer status. Every client is to receive a PT screen following each fall, even if no injury. Client will also be placed on 15 minute checks until the IDT can meet and develop plan. Clients who are not sleeping should have a BIR written. When client is not sleeping, conduct a sleep study to determine if meds should be adjusted or needed. Plan needs to be written as to what staff should do with client should s/he wake up. Review client's BSP and make appropriate revisions if fall is related to targeted behavior or target behavior needs to be added Outreach services form to be completed at time of fall. Are we getting enough information from this? QMRP/PD to review number of falls each week. Review care plan, formal goal, BSP, assessments, etc. to ensure revision of necessary areas. After recurrent falls, what is level of supervision to keep client safe?Housekeeping staff has</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  07/22/2013
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>A request for clients #27, #28 and #30's repositioning schedules and/or documentation to indicate when and how the clients were to be repositioned and transitioned out of their beds and wheelchairs was made on 7/10/13 at 1:40 P.M.. No documentation was submitted for review to indicate when and how staff were to assist clients #1, #3, #4, #23, #27, #28 and #30's with repositioning themselves.</p> <p>An interview with Registered Nurse (RN) #7 was conducted on 7/12/13 at 1:30 P.M.. RN #7 indicated clients #1, #3, #4, #23, #27, #28 and #30 used their wheelchairs at all times and further indicated the clients' ISPs did not have guidelines on how and when staff were to assist the clients in positioning themselves in and out of their wheelchairs. The RN further indicated all clients should be repositioned every two hours.</p>		<p>been inserviced to not enter a clients room to clean/mop when the client is in the room and to not block entrance of client bedrooms with the cleaning carts. All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a care plan regarding sling usage for these clients. Staff will be inserviced All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed and staff inserviced on how to elevate their legs, length of time they should be elevated, and where to elevate their legs. Team will complete an IDT. Staff will be inserviced on sling usage. IV For any fall with injury or multiple falls, (for more than 1 fall in any 3 month period), administrative team will review the IDT minutes (which will include discussion of PT recommendations and investigation findings) and follow up. For falls, physical therapy will be consulted if there is a question as to whether a PT screening/assessment is in order. The team will review care plans to assure they are updated to reflect IDT/PT</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  07/22/2013
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>2. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 7/8/13 at 2:45 PM and on 7/9/13 at 2:30 PM. The facility's 12/14/12 reportable incident report indicated "...Housekeeping staff alerted nursing that [client #132] fell on 12/12/2012 in her room in her doorway after housekeeping mopped the floor and placed a wet floor sign in her room. [Client #132] was sleeping in her bed at the time housecleaning was cleaning her room. [Client #132] experienced a laceration to the outer aspect of the eyebrow on her left eye. Nursing immediately assessed [client #132] and had [client #132] sent via ambulance to [name of hospital] ER (emergency room) for evaluation of her wound. [Client #132] returned from the hospital on 12/14/2012 with a new diagnosis of facial</p>		<p>recommendations. CST documentation will be updated to reflect any changes. Client Advocates will review fall procedure application as part of investigation to assure consistent application. QMRP staff will observe prescribed use of sling when completing the transfer observations with those residents who use slings. Corrections to be completed by August 21, 2013.</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  07/22/2013
--	---	--	---

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>laceration and nasal bone fracture. The laceration to the eyebrow of the left eye was closed with glue by the physician in the ER. A CT scan performed in the ER concluded that there were fractures in the upper nasal area and the facial area below the left eye. CT was unable to determine the age of these fractures. However, [client #132] does have a history of falls and has recently had fall events on 12/3/2012 and 12/8/2012; of which the fall on 12/3/2012 resulted in injury involving bruising to both eyes. The event on 12/8/2012 resulted in no injury. [Client #132] has been on 15 minute checks and will be closely monitored by staff. [Client #132] has an intervention plan regarding falls and has received an order for a urinalysis and are pending the results of this lab currently. Client was seen by physical therapy on 11/8/2012 which indicated no decline in client's gait...[Client #132] has an order to follow with a plastic surgeon to determine the extent of the fractures and if any corrective procedure needs to be scheduled."</p> <p>The facility's 12/21/12 follow-up report indicated "[Client #132's] fracture and laceration were sustained on the fall that occurred on 12/14/2012. According to the facial CT performed at the hospital, [client #132] sustained simple fractures</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  07/22/2013
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>along the nasal bone and the cheek bone below the left eye...Staff were aware of [client #132's] location at the time of the incident but were not aware the floor was being mopped...."</p> <p>The facility's undated Hospital/ER Report indicated "...During and (sic) investigation of a fall [client #132] sustained on 12/8, 3rd floor staff stated that [client #132] was screaming and wandering more often than usual. It was stated that client was sleeping less and becoming more easily agitated than usual...."</p> <p>The facility's reportable incident reports, Fall Reports, Hospital Reports, BIRs and/or investigations indicated the following:</p> <p>-12/3/12 "Resident (client #132) fell in doorway walking out of room with hands full carrying clothing. Resident struck left side of head and left eye as well as left shoulder on door frame. Nursing notified, and redness noted to sclera of left eye and left eyelid. Redness also noted to left shoulder. No further signs of injury noted at this time, however resident is subject to bruising to left face, shoulder and eye. Neurological assessments completed by nursing and no abnormalities noted...Staff will continue</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  07/22/2013
--	---	--	---

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>to monitor for further falls and follow BSP (Behavior Support Plan), Nursing will continue to monitor for further signs of injury or discomfort."</p> <p>The facility's undated Fall Report indicated client #132 hit her face on the door jam walking out of her room at 3:50 AM. The Fall Report indicated "...[Client #132] has a history and pattern of periods of increased mania which includes not sleeping...Conclusion: [Client #132] has a history of falls related to carrying objects and maladaptive behaviors. She has a fall prevention plan. [Client #132] will continue to be monitored, and redirected to slow down pace...."</p> <p>-12/8/12 "Client up all night yelling, screaming, disturbing peers, running-sleep drunk walking, falling on floor x (times) 3 on buttocks and both sides."</p> <p>An attached 1/24/13 Interdisciplinary Team (IDT) note indicated "A review of [client #132's] chart finds that the formal notes from the IDT were not typed. [Client #132] was up all night yelling and running, She was unsteady and staff described her walk as 'drunk.' She fell to floor 3 times, landing on her buttocks and both sides. There was no apparent injury. Recommendations: [Client #132's]</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  07/22/2013
--	---	--	---

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>behavior plan addresses manic cycles and should continue to be implemented...."</p> <p>-12/10/12 Client #132 got up at night and fell trying to walk out of her bedroom to her buttocks. The Fall report indicated client #132 "fell twice trying to get up." No injuries noted.</p> <p>-12/12/12 Client #132 was walking down hallway with blood dripping from the top of client #132's left side of her scalp. The reportable incident report indicated client #132's fingernails were long, had a "tantrum" on 12/11/12, 12/12/12 and repeated falls.</p> <p>-1/12/13 "[Client #132] was heading into the dining room and was redirected by the hall monitor. She did not respond. The hall monitor called for [client #132's] staff- in the interim, a peer came out and told staff that [client #132] had fallen. She had a laceration to her lip and was taken to the ER." The undated Hospital/ER Report indicated the incident occurred at 8:30 PM on 1/12/13. The report also indicated client #132 received one stitch to her upper lip. The report indicated "...Conclusion:[Client #132] has had multiple falls over the past month. She has been assessed for UTI (Urinary Tract Infection), which was negative. Her physician has been notified. To help</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  07/22/2013	
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>prevent future falls, [client #132's] fall care plan has been revised. As well, North Willow is instituting a program to increase awareness for staff of clients who are at greater risk of falls. Staff will continue to monitor [client #132's] shoes to assure they fit properly and are on the right feet. She will be prompted to slow her rate of walking to help reduce the risk of further falls...."</p> <p>An attached 1/28/13 IDT note indicated client #132's fall plan was revised to include a program (leaf program) to "...increase awareness for staff of clients who are at greater risk of falls...."</p> <p>-4/20/13 Client #132 fell asleep in a chair and fell out of the chair. No injuries noted.</p> <p>-4/21/13 Client #132 left her unit to go back to dining room. The BIR indicated when the client was redirected away from an area where another client had a behavior, client #132 fell to the floor pulling staff to the floor with her. The BIR indicated client #132 slipped on the floor.</p> <p>An attached 4/22/13 IDT note indicated "...[Client #132] fall (sic) due to another resident throwing her plate on the floor and causing [client #132] to slip and</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  07/22/2013	
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>fall...Conclusion: Staff will redirect [client #132] when there are unsafe areas. Staff will ensure areas are save (sic) and free of spills, if able...."</p> <p>-6/15/13 "Client tripped and fell and hit head on side of table causing a laceration on her left eye brow. Client sent to ER for eval (evaluation); and treatment. Client returned from ER a few hours later. Nursing following discharge instructions."</p> <p>The facility's 6/15/13 ER/Hospital Report indicated client #132 received 4 sutures to her left eyebrow due to the fall. The report indicated "...[Client #132] has a history of falls. She has a fall risk plan. She has fallen twice previously this year on 4/20/13 and 4/21/13...Staff will continue to encourage [client #132] to slow down and be more aware of her surroundings. She does have a fall risk plan r/t (related to) impaired safety awareness."</p> <p>An attached 7/3/13 IDT note indicated client #132 fell in the classroom and was sent out to the ER for evaluation receiving 4 sutures to left eye brow.</p> <p>Client #132's record was reviewed on 7/12/13 at 9:44 AM. Client #132's 11/8/12 Physical Therapy (PT) Evaluation</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  07/22/2013
--	---	--	---

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>indicated client #132 "...needs 24/7 supervision for safety and H/O (history of) falls." The PT evaluation indicated client #132's supervision varied "from remote to close dep (depending) on her behaviours (sic)...."</p> <p>Client #132's 3/27/13 PT Screen indicated "Pt (patient) amb (ambulates) (I) (independently) to all distances. When she has a lot of stuff in her hands; she tends to lean fwd (forward) when ambulating (prompt the staff to assist PRN (as needed)). 1st shift staff redirects her to clean out her hands so she can ambulate safely (without) assist. She does not need gait belt but req (require) remote supervision along (with) vcs (verbal cues). When walking fast- She walks on her toes and needs redirection to pace herself."</p> <p>Client #132's 1/16/13 fall risk plan indicated client #132 had a history of falls. The fall risk plan indicated the following (not all inclusive):</p> <p>"-Client has less ability to focus on near objects with aging process as well as with depth perception. 1.) Encourage client to use W/C (wheelchair) prn 2.) Utilize gait belt whenever client is attempting to ambulate unassisted.</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  07/22/2013
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>-Client to have P.T. evaluation to determine if client would benefit from strengthening or balancing programs.</p> <p>-Keep environment well lit and free of clutter.</p> <p>-Remind client to decrease weight of objects in her book bag if bag appears too full. Heavy book bag can cause client to lose her balance when walking.</p> <p>-Report changes of condition to MD (medical doctor) prn.</p> <p>-Staff to remind client to slow down when walking, and to use hand rails in hallway when possible.</p> <p>-Staff to remind client upon waking, after meals, and before going to bed to toilet.</p> <p>-Staff will ensure that client is wearing her designated footwear and wearing them on correctly.</p> <p>-Staff will prompt and assist client when walking through wet areas and areas with clutter."</p> <p>Client #132's IDT notes dated 7/3/13, 5/10/13, 4/22/13, 2/28/13, 1/28/13 and 1/24/13 indicated the facility failed to indicate how client #132 was to be</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  07/22/2013	
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>monitored/supervised when awake at night, to ensure the client was monitored/supervised to prevent falls in the client's bedroom, and/or to prevent injuries which resulted in ER trips/sutures/fractures. Client #132's 3/13 PT evaluation and/or 10/12 Individual Support Plan (ISP), and/or 1/13 risk plan did not specifically indicate/define "remote supervision."</p> <p>Interview with Program Director (PD) #2 on 7/12/13 at 1:30 PM indicated client #132 was a fall risk. PD #2 indicated the facility initiated 15 minute checks after the falls with injuries. PD #2 indicated client #2 was no longer on 15 minute checks. PD #2 indicated client #132 did not utilize a gait belt and did not require staff to be with the client when ambulating. PD #2 indicated client #132 would wake up at night and get out of her bed. PD #2 indicated client #132's ISP and/or risk plan did not indicate how client #2 was to be supervised and/or clearly define remote supervision to prevent further injuries/fractures.</p> <p>3. Observations were completed at the facility on 7/8/13 from 3:25 PM until 6:25 PM. Client #24 took a shower at 3:50 PM. At 4:20 PM, client #24 was in the program room adjacent to the back entrance to the facility's first floor playing</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  07/22/2013	
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>solitaire on the computer while sitting in her wheelchair. At 5:20 PM, client #24 sat in the dining room. Her lower left calf had a dark purple color.</p> <p>Program Director (PD) #1 was interviewed on 7/8/13 at 5:51 PM and indicated the purple coloration of client #24's legs was typical for client #24. She indicated client #24 was using her old wheelchair while her current wheelchair was being repaired. PD #1 indicated client #24's wheelchair would provide more elevation for her legs and feet when it was repaired. She indicated it was a 30 day wait for foot rests and client #24 was a diabetic which contributed to the issue of purple coloration of her legs.</p> <p>Client #24 was interviewed on 7/8/13 at 6:25 PM and indicated she was unable to move her left leg due to a car accident when she was 2 years of age. She indicated this was her wheelchair, but she was unable to get her legs elevated with the footrests in the wheelchair.</p> <p>During observation at the facility on 7/8/13 from 7:07 AM until 8:25 AM, client #24's lower legs were a light purple color as she sat in the dining room for breakfast.</p> <p>Client #24 record was reviewed on</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  07/22/2013	
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>7/11/13 at 3:58 PM. A care plan dated 4/10/13 indicated client #24 had altered skin integrity related to an open lesion. The care plan indicated "non Weight Bearing while lesion heals on plantar surface of left heel...Client is to keep foot elevated...Bunny Boot to LT (left) foot until healed." Physician's orders dated 7/1/13-7/31/13 indicated "Client to have elevating leg rest on w/c.(sic) to keep feet elevated." A 6/5/13 note indicated client #24's wound was healed. A 6/28/13 progress note indicated "Both lower extremities are slightly edematous (fluid buildup), and Client is encouraged to elevate them while up in the wheelchair." There was no evidence in the record of a schedule for client #24 to elevate her leg. An Occupational Therapy Evaluation dated 4/18/13 indicated "She would highly benefit from elevating leg rests...L LE (lower extremity) has very poor circulation...Pt is to keep her legs elevated for periods during the day...."</p> <p>Client #24 was interviewed on 7/12/13 at 9:45 AM and indicated she did not have time set aside in her day to elevate her legs, and indicated her wheelchair was being returned today.</p> <p>CNA (Certified Nursing Aide) #59 was interviewed on 7/12/13 at 10:20 AM. When asked if client #24 had an</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  07/22/2013	
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>opportunity to get out of her wheelchair or elevate her feet during the day, she stated, "No."</p> <p>Program Director (PD) #1 and QIDP (Qualified Intellectual Disabilities Professional) #3 were interviewed on 7/12/13 at 12:40 PM. When asked if client #24 had opportunity or a schedule for elevating her legs, PD #1 indicated there was no schedule for client #24 to elevate her legs. She indicated client #24 refused offers to do so as she would need to get into bed to do so and stated, "she is social."</p> <p>Client #24's Individual Support Plan dated 4/11/13 was reviewed on 7/15/13 at 11:15 AM and did not address refusals to elevate her legs or evidence of nursing education regarding the importance of elevating her legs for health.</p> <p>3.1-35 (b)(1)</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  07/22/2013
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	
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, 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 8 of 16 sampled clients (clients #1, #3, #6, #7, #8, #9, #11 and #15) and 16 additional clients (#21, #22, #23, #24, #29, #59, #64, #66, #68, #71, #72, #76, #78, #83, #142 and #148), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed.</p> <p>Findings include:</p> <p>1. Observations were conducted on the West wing of the 2nd floor of the facility on 7/8/13 between 3:15 PM and 5:45 PM. Client #8 was in his bed lying down from 3:15 PM until 4:10 PM. A 4:10 PM client #8 was escorted to the West wing classroom where he sat in a straight chair near the door and rocked his body back and forth on the chair. At 4:17 PM client #8 got up to use the bathroom and returned to the same straight chair, took off his shoes and sat rocking back and forth. Staff #1 spoke with client #8 one</p>	W000249	<p>W249</p> <p>I Staff have been re-inserviced on goals and active treatment schedules for client #1, 3, 6, 7, 8, 9, 11, 15, 21, 22, 23, 24, 29, 59, 64, 66, 68, 71, 72, 76, 78, 83, 142, and 148. Staff have been re-inserviced on client #64's Behavior Support Plan. Nursing staff have been re-inserviced on implementing self-medication training at all available opportunities.</p> <p>For sited resident (s) nurse has been retrained to complete medication goals at each time of medication pass.</p> <p>II All residents might be at risk for this deficient practice.</p> <p>III Active Treatment Schedules have been reviewed by the QMRP and modified as needed. Additionally, Active Treatment Schedules will be posted conspicuously in each classroom. PDs have retrained QMRPs on program implementation and their</p>	08/21/2013	

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  07/22/2013	
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>time during this observation to prompt client #8 into an activity and the client refused. The staff did not prompt client #8 to put his shoes back on.</p> <p>__ Client #9 sat in a wheelchair in the West wing classroom from 3:15 PM until 5:10 PM. Staff #3 indicated client #9 was blind and immobile. At 3:40 PM client #9 was asked by staff #3 if she wanted to participate in kicking a ball around the room. Client #9 did not respond to the staff. At 4:30 PM, client #9 was handed a bean bag and asked to hold it. Client #9 held the bean bag for a few seconds and then dropped it in her lap. At 5:10 PM client #9 was escorted to the dining room for her evening meal.</p> <p>__ Client #64 sat in a wheel chair in the West wing classroom from 3:15 PM until 5:30 PM. During this entire observation, client #64 chewed on her hands and clothing and sucked on her thumb. At 3:35 PM QIDP (Qualified Intellectual Disabilities Professional) #1 placed a large ball in client #64's lap. Client #64 let the ball drop to the floor and continued to chew on her right hand and clothing.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 6:10 AM and 8:20 AM.</p> <p>__ Client #8 was in bed during this entire observation. Staff #7 walked in and out of client #8's room twice during this</p>		<p>role in active treatment. DNS/Designee has retrained nurses on importance of implementing all self-medication goals at all available opportunities. ED/Designee will retrain the Staffing Scheduler in regards to consistent CNA placement to improve quality of care and increase program implementation. Nurses have been retrained to complete medication goals at each time of medication pass.</p> <p>IV DCE/Designee audits medication passes to ensure implementation of self-medication goals is occurring. PDs and QMRPs regularly make rounds and complete observation-based audits to monitor specifically for program implementation and active treatment. ED/PDs regularly monitor the daily staffing assignments to best meet needs of the residents. During medication audits, medication goal implementation will also be observed. Corrections to be completed by August 21, 2013.</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  07/22/2013
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>observation.</p> <p>__At 6:40 AM staff #6 got client #9 up, bathed and into a wheelchair. At 6:57 AM client #9 was wheeled to the West wing classroom where she sat in the wheelchair, without activity and/or offer of training from the staff until 7:30 PM when she was escorted to the dining room for her morning meal.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/10/13 from 2:30 PM to 4 PM. Client #8 was in his bed lying down throughout the observation. Client #9 was lying in her bed until 3:30 PM where she sat in a wheelchair in her bedroom without activity until 4 PM at which time she was wheeled into the classroom on the West wing. Client #64 was brought to the West wing classroom at 3:30 PM. From 3:30 PM throughout the remainder of the observation, client #64 sucked on her thumb and chewed on her shirt she was wearing.</p> <p>During AM and PM observations the staff did not prompt and/or offer clients #8, #9 and #64 training objectives and/or leisure activities when time allotted. During PM observations the staff did not attempt to determine what the problem was with client #64 in regard to her sucking her thumb and chewing on her clothing. The</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  07/22/2013
--	---	--	---

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>staff did not sing to client #64, verbally prompt client #64 to stop her behaviors, use a light touch to client #64's hands and/or redirect client #64 to an alternative activity.</p> <p>Client #8's record was reviewed on 7/12/13 at 2 PM. Client #8's ISP (Individual Support Plan) of 8/7/12 indicated client #8 had training objectives to touch the four basic coins (penny, nickel, dime and quarter), to identify various objects in his environment, to keep his shoes on and to hold an object for 5 seconds.</p> <p>Client #9's record was reviewed on 7/12/13 at 3 PM. Client #9's ISP of 10/25/12 indicated the client had training objectives to choose between two tactile items and to feel the difference between a dollar and a quarter.</p> <p>Client #64's record was reviewed on 7/10/13 at 2 PM. Client #64's ISP of 7/2/13 indicated the client had training objectives to participate in at least one prevocational activity, to visualize various coins as staff identified them and to participate in at least one activity with her peers. Client #64's BSP (Behavior Support Plan) of 7/2/13 indicated client #64 had targeted behaviors of SIB (self injurious behaviors). The SIB was</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  07/22/2013
--	---	--	---

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>displayed as biting her thumb and self-stimulation of putting her thumb or the neckline of her clothing into her mouth to suck on. The BSP indicated client #64 was to be provided with daily structured programming as well as items and activities to enhance her leisure time. The BSP indicated the staff were to "Present her with two items and encourage her to choose an activity." The BSP indicated when client #64 presented with SIB the staff were to:</p> <p><input type="checkbox"/> Attempt to determine what the problem is and address it, if possible.</p> <p><input type="checkbox"/> Try singing to her.</p> <p><input type="checkbox"/> Verbally prompt her to stop the behavior.</p> <p><input type="checkbox"/> Use a light touch to her hands to stop the behavior and redirect her to an alternative activity.</p> <p><input type="checkbox"/> Give her verbal and gentle tactile praise when calm.</p> <p><input type="checkbox"/> Repeat previous steps as needed for SIB.</p> <p>The BSP indicated "Should SIB continue: remove [client #64] from the area and take her where she can be counseled in a quiet environment."</p> <p>During telephone interview with PD (Program Director) #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM, the PD stated the staff were to offer the</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 07/22/2013	
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>clients training and/or leisure activities "every 10 to 15 minutes." The PD indicated whenever client #64 was showing signs of SIB the staff were to try to figure out what the problem was, redirect her, offer her activities and/or remove her from the area depending on the extent of the SIB. The PD stated clients "should not be sitting without activity for long periods of time."</p> <p>2. During observations of the medication pass on the second floor of the facility on 7/8/13 between 4 PM and 6:15 PM the following was observed:                  ___ At 4 PM, RN (Registered Nurse) #8 gave client #59 MOM (Milk of Magnesia) (for abdominal gas), Risperdal (an antipsychotic), Tegretol (an anticonvulsant) and Colace (a stool softener). RN #8 did not inform client #8 that it was time to take her medications. RN #8 walked into the classroom and began spoon feeding client #8 her medications.                  ___ At 4:10 PM, RN #8 gave client #72 Zyprexa (an antipsychotic), Levetiracetam (an anticonvulsant) and Calcium with Vitamin D. RN #8 did not inform client #72 that it was time to take his medications. RN #8 walked into the classroom and began spoon feeding client #72 his medications.                  ___ At 4:17 PM, RN #8 gave client #66</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  07/22/2013
--	---	--	---

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>Potassium, Valproic acid (for seizures) and artificial tears in both eyes. Client #66 did not throw his medication cup in the trash.</p> <p>__At 4:25 PM, RN #8 gave client #78 Colace. RN #8 walked into the classroom and gave client #78 his medications. Client #78 did not come to the medication cart for his medications and the RN did not prompt the client to come to the medication cart.</p> <p>__At 6:15 PM, RN #8 gave client #68 his tube feeding of Jevity, Colace, Magnesium Hydroxide (a mineral substitute) and Simethicone (for gas). Client #68 did not hold up his shirt for his tube feeding.</p> <p>During the PM observation of the medication pass, RN #8 did not provide clients #59, #72, #66, #68, and #78 any training in regard to the medications taken and/or informed the clients of the medications given.</p> <p>During observations of the medication pass on the second floor of the facility on 7/9/13 between 7 AM and 8:35 AM the following was observed:</p> <p>__At 7:10 AM LPN (Licensed Practical Nurse) #6 gave client #78 MOM and Colace. LPN #6 took client #6 his medications to him in his bedroom. LPN #6 did not prompt client #78 to come to</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  07/22/2013
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>the medication cart.</p> <p>__At 7:30 AM LPN #6 gave client #76 Cozaar (for hypertension), Depakote (an anticonvulsant), Lasix (a diuretic), Potassium and Calcium. LPN #6 took client #76 her medications to her in her bedroom.</p> <p>__At 7:50 AM, LPN #6 gave client #71 Vitamin D, Colace, Tegretol, Bethanechol Chloride (for urinary problems), Depakote and insulin. Client #71 did not lean back and hold up his shirt to get his insulin. LPN #6 did not prompt client #71 to raise his shirt and/or to lean back to receive his insulin.</p> <p>__At 8:35 AM, LPN #6 gave client #8 his tube feeding of Jevity, Zyprexa and a mouth wash. Client #8 did not raise up in his bed to get his tube feeding. LPN #6 did not ask client #8 to raise up to get his tube feeding.</p> <p>During the AM observation of the medication pass, LPN #6 did not provide clients #8, #71, #76 and #78 any training in regard to the medications taken and/or informed the clients of the medications given.</p> <p>Client #8's record was reviewed on 7/12/13 at 2 PM. Client #8's ISP of 8/7/12 indicated client #8 had a training objective to raise up for his g-tube 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  07/22/2013	
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>Client #59's record was reviewed on 7/10/13 at 2:45 PM. Client #59's ISP of 8/21/12 indicated client #59 had a training objective to open her mouth to receive her medication. The ISP indicated the nurse was to inform client #59 it was time for her medications and using the least amount of prompting, have client #59 open her mouth for her medications.</p> <p>Client #66's record was reviewed on 7/10/13 at 2:45 PM. Client #66's ISP of 11/13/12 indicated client #66 had a training objective to trash his medication cup after taking his medications.</p> <p>Client #68's record was reviewed on 7/10/13 at 2:45 PM. Client #68's ISP of 12/11/12 indicated client #68 had a training objective to hold his shirt up while receiving his tube feeding.</p> <p>Client #71's record was reviewed on 7/10/13 at 2:45 PM. Client #71's ISP of 4/1/13 indicated client #71 had a training objective to hold his shirt for his insulin injections.</p> <p>Client #72's record was reviewed on 7/10/13 at 2:45 PM. Client #72's ISP of 7/3/12 indicated client #72 had a training objective to open his mouth to receive his medications. The ISP indicated the nurse</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  07/22/2013	
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>was to inform client #72 it was time for his medications and using the least amount of prompting, client #72 was to open his mouth for his medications.</p> <p>Client #76's record was reviewed on 7/10/13 at 2:45 PM. Client #76's ISP of 11/1/12 indicated client #76 had a training objective to identify her Colace.</p> <p>Client #78's record was reviewed on 7/10/13 at 2:45 PM. Client #78's ISP of 6/1/13 indicated client #78 had a training objective to come to the medication cart to take his medications.</p> <p>Interview with the DON (Director of Nurses) on 7/10/13 at 3 PM stated the nurses were to offer medication training with each medication pass and were to "run their goals" daily.</p> <p>During telephone interview with PD #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM, the PD #3 indicated training objectives were to be offered at every available opportunity.</p> <p>3. Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. There were male and female clients in the classroom. Client #6 was seated at a table</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  07/22/2013
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>with snap together building blocks placed on the table in front of her. At 3:20 P.M. client #6 was prompted by CNA #70 "Build your house." Client #6 did not participate in the activity. At 3:42 P.M. client #6 was offered a shape sorter. Client #6 did not utilize the shape sorter. CNA #70 read several books to the class, and asked some of the clients in the class questions about the book. At 4:13 P.M. CNA #72 prompted client #6 to wash her hands for dinner. Client #6 walked to the dining room for dinner with staff assistance at 5:21 P.M. During the observation time period client #6 was not wearing an undergarment under her shirt and lifted her top exposing her abdomen and breast(s) eight (8) times.</p> <p>Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #7 was seated in a chair by the window. Client #7 was holding a magazine, but not looking at it. At 3:28 P.M. client #7 stood up and CNA #71 prompted him to use the restroom. Client #7 began to pull his pants down as he walked to the restroom. CNA #71 physically redirected client #7 to keep his pants up. At 3:42 P.M. client #7 stood up and was verbally prompted to sit back down. At 3:55 P.M. client #7 was assisted to the rest room and then returned to his chair by the window. At 3:58 PM,</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  07/22/2013
--	---	--	---

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>client #7 stood up and walked ten (10) feet independently. CNA #72 then assisted him to walk out to the hallway out one class room door and into the other class room door back to his chair by the window. When client #7 stood up again CNA #70 asked him "Do you want to go to your room?" Client #7 sat back down quickly. Client #7 stood up three (3) more times and was verbally prompted to sit back down. CNA #71 stated, "Be good [client #7]." At 4:04 P.M. CNA #70 put a gait belt on client #7. Client #7 then sat quietly looking out the window. At 4:44 P.M. client #7 stood up. CNA #70 stated, "[Client #7] do you want to go to your room now?" Client #7 sat down. CNA #70 then stated, "Well alright then." Client #7 began to page through his magazine, about five pages, and stopped. This was the same magazine he had since 3:20 P.M. At 5:03 P.M. client #7 stood up and walked away from his chair. CNA #70 returned client #7 to his chair by grasping the back of his gait belt. At 5:08 P.M. Program Director (PD) #3 entered the class room and client #7 got up and walked to the PD. Client #7 stated to PD #3, "Go out? Want ice cream. No want pizza." Client #7 then saw a magazine belonging to a female classmate. Client #7 briefly paged through the magazine, but left it on his peer's chair. At 5:18 P.M. PD #3 assisted client #7 with washing his</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  07/22/2013
--	---	--	---

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>hands for dinner. PD #3 then walked with client #7 to the dining room assisting him by holding on to the back of his gait belt as he walked.</p> <p>Client #6's record was reviewed on 7/11/13 at 1:50 P.M. Client #6's Individual Support Plan (ISP) dated 9/13/12 included, but was not limited to, the following goals: "put on a tank top under shirt, complete assigned task, identify functional items in her environment, wash hands after toileting, identify coins, share activity with peers, and walk for fifteen minutes."</p> <p>Client #7's record was reviewed on 7/11/13 at 4:10 P.M. Client #7's ISP dated 2/5/13 included, but was not limited to, the following goals: "will be able to demonstrate appropriate greeting, trace objects/items, identify objects, point to a dollar bill and remain on task."</p> <p>An interview was conducted with QIDP #2 on 7/12/13 at 12:09 P.M. When asked about client #6 lifting up her shirt, QIDP #2 stated, "Staff should have prompted her to put her shirt down. If she was not wearing a tank under her shirt, then staff did not work on that goal with her. She does have a goal to wear a tank under her top." When asked what clients #6 and #7 were to do while in class, QIDP #2 stated,</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  07/22/2013	
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>"The staff will choose an activity they are to do. It may be a physical activity, reading, sharing or manipulating items." QIDP #2 indicated client #7 needed to remain seated due to a history of falling and elopement. QIDP #2 indicated client #7's elopement had greatly decreased as he was not as quick as he used to be.</p> <p>4. Observations on second floor were conducted on 7/9/13 from 1:05 P.M. until 2:13 P.M. Client #83 was walking around the hallway in and out of the classroom. Client #83 was drooling. She did not have anything to wipe her mouth/chin with and the front of her shirt was wet. The staff on duty did not redirect her or offer her an activity.</p> <p>Client #83 was interviewed on 7/9/13 at 1:16 P.M. Client #83 indicated by sign "Her mother was injured in a car accident and had broken her leg." Client #83 signed she was "Sad about her mom, and wanted to go home to help her." Client #83 had a note from her mother which indicated her mom had called her and would be coming soon. The Note indicated client #83's mother had a toothache. Client #83 again signed "Want to go home to help mom." Client #83 signed the staff tell (sign) for her to "stay" and "finished with you." Client #83 signed her only friend was [Social Worker</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  07/22/2013	
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>#1]. Client #83 indicated she was fed via tube. Client #83 signed she had a puppy at home, and did not like living at the facility. During the time between 1:16 P.M. and 2:13 P.M. client #83 was not interacted with staff at the facility.</p> <p>5. Client #11 was observed on 7/9/13 from 5:16 A.M. until 8:55 A.M.. From 5:33 A.M. until 7:32 A.M., client #11 intermittently stood in the door way of his bedroom and sat on his bed without programming or interaction from staff. CNAs (Certified Nursing Aides) #177, #178, and #179 were not observed to prompt or assist client #11 to complete activity of choice or identify various coins or bills.</p> <p>Client #15 was observed on 7/9/13 from 5:16 A.M. until 8:55 A.M.. From 6:25 A.M. until 7:32 A.M., client #15 sat in his wheelchair in the program room without programming or interaction from staff. CNAs (Certified Nursing Aides) #177, #178, and #179 were not observed to prompt or assist client #15 to participate in programming with peers or identify a simple coin combination.</p> <p>Client #142 was observed on 7/9/13 from 5:16 A.M. until 8:55 A.M.. From 5:25 A.M. until 7:32 A.M., client #142 sat in the program room without programming</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  07/22/2013	
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>or interaction from staff. CNAs (Certified Nursing Aides) #177, #178, and #179 were not observed to prompt or assist client #142 to point to pictures of familiar items or match coins.</p> <p>Client #148 was observed on 7/9/13 from 5:16 A.M. until 8:55 A.M.. From 5:16 A.M. until 7:32 A.M., client #148 sat in the program room without programming or interaction from staff. CNAs (Certified Nursing Aides) #177, #178, and #179 were not observed to prompt or assist client #148 to remain of task for five minutes or to make a choice between two functional objects.</p> <p>Client #11's record was reviewed on 7/11/13 at 6:42 A.M.. A review of client #11's 4/10/13 Individual Program Plan indicated the client had the following objectives which could have been implemented during the 7/9/13 observation period. 1. Complete activity of choice. 2. Identify various coins or bills.</p> <p>Client #15's record was reviewed on 7/11/13 at 8:03 A.M.. A review of client #15's 4/29/13 Individual Program Plan indicated the client had the following objectives which could have been implemented during the 7/9/13 observation period. 1. Participate in</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  07/22/2013	
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>programming with peers. 2. Identify a simple coin combination.</p> <p>Client #142's record was reviewed on 7/11/13 at 1:34 P.M.. A review of client #142's 10/18/12 Individual Program Plan indicated the client had the following objectives which could have been implemented during the 7/9/13 observation period. 1. Point to pictures of familiar items. 2. Match coins.</p> <p>Client #148's record was reviewed on 7/11/13 at 1:56 P.M.. A review of client #148's 3/21/13 Individual Program Plan indicated the client had the following objectives which could have been implemented during the 7/9/13 observation period. 1. Remain on task for five minutes. 2. Make a choice between two functional objects.</p> <p>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 indicated CNAs #177, #178, and #179 should have implemented objectives for clients #11, #15, #142, and #148 during times of opportunity during the 7/9/13 morning observation period.</p> <p>6. Observations were conducted on 7/8/13 from 1:00 P.M. until 2:00 P.M. and 2:30 P.M. until 6:25 P.M.. During the entire observation period, client #1 sat</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  07/22/2013
--	---	--	---

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>in the day room with no activity and client #4 propelled his wheelchair back and forth to and from the day room, and client #3 sat in his bedroom, sitting in a wheelchair with no activity. Certified Nursing Aides (CNA) #26, #27 and #28 would walk into the rooms and occasionally check on clients #1, #3 and #4, but did not offer any meaningful activity. During the above mentioned observation period, clients #1 and #3 were non-verbal in communication in that the clients did not speak. No communication training was provided and/or offered to each client.</p> <p>At 4:03 P.M., Licensed Practical Nurse (LPN) #2 began administering client #22's prescribed medication. LPN #2 took each of client #2's medication packets out of the medication cart, popped each medication into a clear plastic cup and administered client #22's medication. LPN #2 did not teach or train client #22 the purpose of taking her medications.</p> <p>At 4:13 P.M., LPN #2 began administering client #24's prescribed medication. LPN #2 took each of client #24's medication packets out of the medication cart, popped each medication into a clear plastic cup and administered client #24's medication. Client #24 was not prompted and did not state the</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  07/22/2013	
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>signs/symptoms of low blood sugar.</p> <p>At 4:36 P.M., LPN #2 began administering client #1's prescribed medication. LPN #2 took each of client #1's medication packets out of the medication cart, popped each medication into a clear plastic cup and administered client #1's medication. Client #1 was not prompted and did not make eye contact for 5 seconds during this med pass.</p> <p>At 4:51 P.M., LPN #2 began administering client #21's prescribed medication. LPN #2 took each of client #21's medication packets out of the medication cart, popped each medication into a clear plastic cup, walked into client #21's bedroom and administered client #21's medication. Client #21 was not prompted and did not come to the med cart.</p> <p>At 5:00 P.M., LPN #2 began administering client #23's prescribed medication. LPN #2 took each of client #23's medication packets out of the medication cart, popped each medication into a clear plastic cup and administered client #23's medication. LPN #2 did not teach or train client #23 about her prescribed medications.</p> <p>At 5:08 P.M., LPN #2 began</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  07/22/2013
--	---	--	---

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>administering client #29's prescribed medication. LPN #2 took each of client #29's medication packets out of the medication cart, popped each medication into a clear plastic cup and administered client #29's medication. Client #29 was not prompted and did not state the purpose of his medications.</p> <p>A review of client #1's record was conducted on 7/11/13 at 9:30 A.M.. The Individual Support Plan (ISP) dated 8/14/12 indicated: "Will stay on task...Will enhance his communication skills by responding with eye contact when staff calls his name...Will participate in activities...Will make eye contact with nursing for 5 seconds during med pass..."</p> <p>A review of client #3's record was conducted on 7/11/13 at 2:00 P.M.. A review of client #3's ISP dated 1/31/13 indicated: "Will respond with eye contact when his name is called...Will visualize various coins as staff identify them..."</p> <p>A review of client #21's record was conducted on 7/12/13 at 8:30 A.M.. The ISP dated 1/17/13 indicated: "Will learn skills to report to the med cart by coming to the med cart."</p> <p>A review of client #22's record was</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  07/22/2013	
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>conducted on 7/12/13 at 8:40 A.M.. The ISP dated 6/20/13 indicated: "Will learn the purpose of taking her medications."</p> <p>A review of client #23's record was conducted on 7/12/13 at 8:55 A.M.. The ISP dated 12/4/12 indicated: "Will demonstrate understanding of the purpose of taking her medications."</p> <p>A review of client #24's record was conducted on 7/12/13 at 9:15 A.M.. The ISP dated 4/11/13 indicated: "Will state the signs/symptoms of low blood sugar."</p> <p>A review of client #29's record was conducted on 7/12/13 at 9:30 A.M.. The ISP dated 10/18/12 indicated: "Will be able to understand the purpose of his medications by stating the purpose of his medications."</p> <p>An interview with Qualified Intellectual Disabilities Professional (QIDP) #3 and Program Director (PD) #1 was conducted on 7/12/13 at 12:40 P.M.. QIDP #3 and PD #1 indicated facility staff should implement training objectives at all times of opportunity.</p> <p>3.1-32(a) 3.1-33(a) 3.1-37(a)</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  07/22/2013
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	
W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview for 5 of 15 sampled clients (#3, #6, #7, #10 and #13) plus 6 additional clients (#48, #84, #95, #107, #125 and #148), the facility failed to promote the clients' independence, growth and dignity.</p> <p>Findings include:</p> <p>1. Observations were conducted on the third floor south wing of the facility on 7/8/13 from 4:45 PM through 5:45 PM. Client #13 was observed throughout the observation period. Client #13 wore a black polo style shirt with yellow stripes across the lapel area. At 4:50 PM client #125 entered the dining room area. Client #125 was not wearing a bra. Client #125's breasts were visible at her waistline. Client #125 remained in this condition throughout the observation period.</p> <p>Observations were conducted on the third floor south wing of the facility on 7/9/13 from 7:45 AM through 8:45 AM. Client #13 was observed throughout the observation period. Client #13 wore a black polo style shirt with yellow stripes across the lapel area. Client #13 wore the</p>	W000268	<p>W268 The IDT will review clients #6, #7, #10, #48, #84, #95, #125 in regard to the need for an ADL skill goal for appropriate dress.</p> <p>The QDDP or designee will complete Active Treatment Observations including observation of personal appearance, three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #6, #7, #10, #48, #84, #95, #125, and all remaining clients. If the remaining clients do not have the appropriate personal appearance the IDT will meet to determine if the need is still present for an ADL skill goal. The QDDP will complete training with staff on any newly implemented goals.</p> <p>The PD will review the Active Treatment observations weekly and complete retraining as needed.</p> <p>The QDDP and/ or PD will complete retraining with staff regarding Personal Appearance/ Dignity.</p> <p>The IDT will review clients #3, #107, and #148 in regard to</p>	08/21/2013	

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  07/22/2013
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>same shirt he had worn on 7/8/13. Client #13 was not redirected to put on a new/clean shirt. At 8:00 AM client #125 entered the unit hallway with her peers. Client #125 was not wearing a bra. Client #125's breasts were visible at her waistline. Client #125 remained in this condition throughout the observation period.</p> <p>PD (Program Director) #3 was interviewed on 7/9/13 at 9:45 AM. PD #3 indicated client #13 should wear clean clothing each day. PD #3 indicated client #125 has bras available for her use and should be encouraged to wear her bra.</p>		<p>minimizing drooling and infection control. The QDDP or designee will complete Active Treatment Observations including observation of personal appearance, three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #3, #107, and #148 and all remaining clients.</p> <p>The PD or designee will complete Handwashing/ Infection Control training with staff, including Activity staff. The QDDP, PD or designee will complete Active Treatment Observations including observation of activities, three times weekly and provide feedback to the staff at the time of the observation.</p> <p>The PD will review the Active Treatment observations weekly and complete retraining as needed.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III The QDDP or designee will complete Active Treatment Observations including observation of personal appearance, three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #6, #7, #10, #48, #84, #95, #125, and all remaining clients. If</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  07/22/2013
--	---	--	---

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>the remaining clients do not have the appropriate personal appearance the IDT will meet to determine if the need is still present for an ADL skill goal. The QDDP will complete training with staff on any newly implemented goals.</p> <p>The QDDP or designee will complete Active Treatment Observations including observation of personal appearance, three times weekly and provide feedback to the staff at the time of the observation.</p> <p>The QDDP and/ or PD will complete retraining with staff regarding Personal Appearance/ Dignity.</p> <p>The QDDP or designee will complete Active Treatment Observations including observation of personal appearance, three times weekly and provide feedback to the staff at the time of the observation. The observations will include clients #3, #107, and #148 and all remaining clients. For other residents who exhibit issues with drooling the IDT will meet to determine if the need is still present for a goal. The QDDP will complete training with staff on any newly implemented goals.</p> <p>The PD or designee will complete Hand washing/ Infection Control</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  07/22/2013
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>2. Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. At 3:31 P.M., Client #6 pulled her top up exposing her abdomen and breast. No redirection was given for her to put her top down. Client #6 put her hands under her top, pulling her top up to her mouth exposing her abdomen and breast(s) seven more times during the observation period at 4:04 P.M., 4:12 P.M., 4:37 P.M., 4:44 P.M., 4:55 P.M. 5:03 P.M. and 5:14 P.M. Certified Nursing Aides (CNA)s #70, #71 and #72 were located in the classroom during the observation time period. CNA #72 verbally prompted client #6 to put her shirt down at 4:14 P.M. and 4:42 P.M. CNA #71 physically assisted client #6 with putting her shirt</p>		<p>training with staff, including Activity staff.</p> <p>IV The QDDP, PD or designee will complete Active Treatment Observations including observation of activities, three times weekly and provide feedback to the staff at the time of the observation.</p> <p>The PD will review the Active Treatment observations weekly and complete retraining as needed. To be completed by 8-21-13.</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  07/22/2013
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>down at 5:12 P.M.</p> <p>-Client #7 was wearing black track pants with a zipper at the bottom of both pant legs, which were unzipped. Client #7's pants were continuously sliding down exposing the top of his buttocks. Client #7's pant legs were dragging the floor and sliding down under the bottom of his shoes. Staff did not assist him to get the pant legs pulled up and zipped to help keep them from sliding down over his shoes. CNA #71 repeatedly prompted client #7 to "pull up your pants," or physically pulled client #7's pants up at the waist without asking him to assist.</p> <p>-Client #48 went to the restroom independently. CNA #71 assisted her with turning on the light and closing the door. When client #48 exited the restroom at 4:06 P.M. her tan capri pants had a darkened area on both inner pant legs at the front between her legs. The area was 12" (twelve inches) by 6" (six inches) in size. At 5:08 P.M. CNA #72 prompted client #48 to use the restroom. When client #48 exited the restroom the dark area in the front of her capri pants was lighter in color, but had a dark rim around the area.</p> <p>An interview was conducted with the facility social worker (SW) on 7/9/13 at</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  07/22/2013
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>7:20 A.M. When asked about client #48 remaining in wet pants for over an hour, the SW stated, "Oh that should never be. She should have been changed right away. She is independent for the most part, but needs some assistance. She shouldn't have been wet for an hour." The SW indicated client #7's pants should have been changed if they did not fit him.</p> <p>An interview was conducted with QIDP #2 on 7/12/13 at 12:09 P.M. When asked about client #6 lifting up her shirt, QIDP #2 stated, "Staff should have prompted her to put her shirt down."</p> <p>An interview was conducted with the PD #3 on 7/12/13 at 12:10 P.M. When asked what staff are to do when client #6 lifts her shirt, PD #3 stated, "She has a goal to wear a tank top under her top. Staff should prompt her to pull her shirt down."</p> <p>3. Observations were conducted on second floor south hall on 7/9/13 at 7:01 A.M.</p> <p>- Client #10 was observed to be sitting in the class room in her wheelchair with bare feet. Client #10 had no shoes, socks or slippers on her feet.</p> <p>-Client #95 was observed to be wearing one (1) short black crew sock and one (1)</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  07/22/2013	
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>white knee high tube sock.</p> <p>-At 8:45 A.M. client #84 was in her wheel chair. She was located in the bedroom belonging to clients #94, #95 and #96 (male clients). Client #84 had a 12" (twelve inches) by 18" (eighteen inches) orange colored stain on the front of her shirt. CNA #76 indicated she did not know why client #84 was in their room or why her shirt was stained.</p> <p>An interview was conducted with the PD #3 on 7/12/13 at 12:10 P.M. When asked clients not wearing shoes and socks, PD #3 stated, "I have recently trained all staff on the importance of clients wearing shoes at all times due to injuries which had occurred."</p> <p>4. An observation was conducted on the first level of the facility on 7/8/13 from 1:00 P.M. until 2:00 P.M.. From 1:00 P.M. until 1:45 P.M., client #3 sat in his wheelchair in his room groaning with no interaction from staff. Client #3 had a white thick mucus substance on his bottom lip, and saliva was dripping from his bottom lip onto his shirt. Client #3 did not have a shirt protector on.</p> <p>An interview with the Director of Nursing (DON) was conducted on 7/12/13 at 1:30 P.M.. The DON stated "Clients who</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  07/22/2013	
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>drool should have clothing protectors on at all times and staff should be assisting them with wiping their faces and checking on them."</p> <p>5. Client #107 was observed during the initial observation period on 7/8/13 from 1:14 P.M. until 2:03 P.M.. Client #107 was drooling excessively throughout the observation. CNAs #12, #13, #14, and #15 did not prompt or assist client #107 in wiping his mouth of excessive saliva.</p> <p>Client #148 was observed on 7/8/13 from 2:59 P.M. until 6:40 P.M.. Client #148 was drooling excessively throughout the observation. CNAs #121, #123, and #124 were not observed to prompt or assist client #148 in wiping his mouth of excessive saliva.</p> <p>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 indicated CNAs #12, #13, #14, #15, #121, #123, and #124 should have assisted or prompted clients #107 and #148 in wiping their mouths of excessive saliva.</p> <p>3.1-3(t)</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  07/22/2013	
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			
W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review the facility failed to meet the Condition of Participation: Health Care Services for 11 of 15 sampled clients (#1, #2, #3, #4, #5, #9, #11, #12, #13, #14 and #15) and 51 additional clients (#23, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148). The facility's Health Care Services failed to meet the nursing needs of clients in regard to obtaining timely medical services for a client with a head injury, monitoring a client skin integrity issues, to ensure an ill client was monitored to prevent further injury, to ensure repositioning schedules were present, to ensuring medications were received as ordered, and clients returned to doctors/audiologist as recommended. The facility's Health Care services failed to ensure quarterly nursing assessments were completed, medications were administered without error and to ensure all medications were locked/secured.</p>	W000318	<p>W318  I For all those residents sited QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.  Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall. QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid. For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other,</p>	08/21/2013			

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  07/22/2013
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>Findings include:</p> <p>1. The facility's Health Care Services failed to ensure its nursing services met the nursing needs of clients to provide client #76 with timely medical services to rule out potential head injury due to fall, monitored/supervised client #76 after a fall resulting in a head injury and instructed the direct care staff in supervising/monitoring and providing client #76 health care in regard to falls with head injury. The facility's Health Care Services failed to ensure its nursing services assessed/monitored client #86 due to skin ulcerations and ensured the staff followed the client's plan of care and documented the client's information, supervised and monitored client #149 to prevent injury resulting in a head injury due to client to client abuse, and repositioned client #9 every 2 hours and documented the position she was placed in on the positioning schedule. The facility's Health care Services failed to ensure its nursing services administered clients #1 and #23's medications as ordered, and to obtain follow-up medical appointments for clients #1 and #3. Please see W331.</p> <p>2. The facility's Health Care Services failed to ensure its nursing services</p>		<p>injury are specified..</p> <p>Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status</p> <p>The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.</p> <p>Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee</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 07/22/2013	
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>conducted quarterly nursing assessments of clients' health status and medical needs for clients #2 and #4. Please see W336.</p> <p>3. The facility's Health Care Services failed to ensure its nursing services ensured all medications were administered without error for 5 of 40 doses administered for clients #24, #71 and #72. Please W369.</p> <p>4. The facility's Health Care Services failed to ensure its nursing services locked all medications until ready for administration which affected 5 of 15 sampled clients (clients #11, #12, #13, #14, and #15) and 50 of 133 additional clients (clients #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) who lived on the third floor of the facility. Please see W382.</p>		<p>and has been trained with staff.</p> <p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan.</p> <p>QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>Nurse for resident 86 has been in-serviced on Wound Evaluation</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  07/22/2013
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>Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</p> <p>Nurse for residents sited have been in-serviced on Medication Administration to ensure medications are passed without error. Nurse for residents sited have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>Nurse for residents sited have been in-serviced to include clear, concise documentation when following a patient's plan of care.</p> <p>Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Re-positioning schedule for client #9 has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT</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  07/22/2013
--	---	--	---

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>will be implemented and documented by direct care staff. All clients who require the use of a sling including client 9 will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced.</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed Medical Director has screened residents 1, 3 and 4's hearing and documented on their annual physical.</p> <p>Nurse for client 2 will monitor vital signs and lung sounds each shift due to risk for aspiration due to emesis during seizures.</p> <p>Resident 1 has a physician order that states Keppra may be crushed.</p> <p>Resident number 23's orders have been reviewed to assure medication is given as prescribed. Nurse for residents 2 and 4 now have updated nursing quarterlies and annuals.</p> <p>Resident 2's nurse has been</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  07/22/2013
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>trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Nursing has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury. Nurses have been trained on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly. Re-positioning schedule those who need repositioning has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Annually at time of physical Medical Director or other physician who performs annual physical will screen and document hearing for each resident. North Willow now has a policy that identifies this screen as our practice. Any issues with the screen and the physician may refer resident to Audiologist. Nursing has been in-serviced on</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  07/22/2013
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>Medication Administration to ensure medications are passed without error.</p> <p>Nursing has been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis.</p> <p>Nursing has been in-serviced to include clear, concise documentation when following a patient's plan of care. Re-positioning schedule for clients who need them were developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and</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  07/22/2013
--	---	--	---

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>when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed</p> <p>Nurses for residents who have emesis during seizures will monitor vital signs and lung sounds each shift due to risk for aspiration.</p> <p>Residents who are prescribed Keppra and need their medication crushed now have an order that states Keppra may be crushed.</p> <p>Residents who take medications have had their orders reviewed to assure medication is given as prescribed. Nursing has been retrained on giving medication as prescribed.</p> <p>Updated Do Not Crush List is located in each MAR.</p> <p>Nursing will be retrained on completing quarterlies and annuals on a timely basis.</p> <p>Nurses have been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>IV Client Advocates will review fall procedure application as part of investigation to assure consistent application.</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  07/22/2013
--	---	--	---

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>Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director.</p> <p>DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis.</p> <p>Active Treatment audits completed by QMRPs and transfer observations will include proper sling use.</p> <p>DCE/DNS/ADNS will audit care plans for those using slings at least quarterly.</p> <p>Health Information Management completes weekly audits that include nursing quarterlies and annuals, DCE, DNS, and ADNS follow up on deficiencies noted on these reports.</p> <p>Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Nursing to audit 15 minute checks each shift to ensure documentation. QMRP to audit daily to assure 15 minute documentation.</p> <p>Corrections to be completed by August 21, 2013.</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  07/22/2013	
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			
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 6 of 15 sampled clients (#1, #2, #3, #4, #5 and #9) and 4 additional clients (#23, #76, #86 and #149), the facility's nursing services failed to meet the nursing needs of the clients. The nursing services failed to:</p> <p>__ Provide client #76 with timely medical services to rule out potential head injury due to fall, monitor/supervise client #76 after a fall resulting in a head injury and instruct the direct care staff in supervising/monitoring and providing client #76 health care in regard to falls with head injury.</p> <p>__ Assess/monitor client #86 due to skin ulcerations and ensure the staff followed the client's plan of care and documented the client's information.</p> <p>__ Supervise and monitor client #149 to prevent injury resulting in a head injury due to client to client abuse.</p> <p>__ Reposition client #9 every 2 hours and document the position she was placed in on the positioning schedule.</p> <p>__ Administer clients #1 and #23's medications as ordered.</p> <p>__ Obtain follow-up appointments for clients #1 and #3.</p>	W000331	<p>W331 I For all those residents sited QA to review fall procedure and assure procedures are in place that provide safeguards to prevent clients from further injury due to falls, to assure clients are monitored and supervised after a fall resulting in injury, and to ensure that timely medical services are provided.</p> <p>Client #76's IDT' will define what level of monitoring/supervision is required following a fall and prior to the suspension of the 15 minute checks. For any fall with injury requiring more than in-house 1st aid, the DNS, Administrator or designee will define specific requirements to continue for the period prior to the meeting of the IDT. Fall procedure will address requesting intervention for potential pain when an injury is sustained from a fall.</p> <p>QA will review the revised fall procedure and assure procedures are in place to accurately identify when a fall requires more than in-house 1st aid.</p> <p>For client #76, and all clients who might fall, the revised procedure directs nursing staff to obtain medical services to rule out potential traumatic head, or other, injury are specified..</p>	08/21/2013			

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  07/22/2013	
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>Findings include:</p> <p>1. A facility BDDS (Bureau of Developmental Disabilities Services) report of 7/12/13 at 9:56 AM reviewed on 7/12/13 at 1 PM indicated on 7/11/13 at 7:15 AM "[Client #76] fell in the bathroom, receiving a 'v' shaped laceration (3 cm x 3 cm) (centimeter) to her forehead and a cut to the bridge of her nose. Steri strips were applied in house. Vitals were taken with her blood pressure reading 195/133, temp 96.2 and O2 saturation 98%. Her physician was contacted and did not order her to be sent out. Due to concerns related to a prior fall with injury to the back of her head (previously reported), [client #76] was sent to [name of hospital] ER. [Client #76] returned yesterday evening with new diagnosis of closed head injury, and facial laceration."</p> <p>Review of the facility falls reports from April 2013 through July 2013 on 7/9/13 at 9 AM indicated:</p> <p>__ On 4/18/13 client #76 walked away from her walker to throw some trash away and fell to her buttocks. No injury was reported.</p> <p>__ On 6/6/13 at 7:20 PM client #76 tripped on a chair and fell, hitting her head on another chair as she went down. The report indicated client #76 obtained a</p>		<p>Nursing staff will be retrained on the need to notify the ED or DNS of any significant changes of status</p> <p>The nurse who treated client #76 will be retrained on documenting blood pressure readings. Staff have been retrained on identification and reporting of abuse and neglect. Client 76 room assignment has been relocated closer in proximity to nurses station, classroom and she is now in the bed closest to the restroom in her room completed. A 1:1 staff was assigned 24/7 beginning 7-11-13 and continued until client 76 was evaluated by Physical Therapy with recommendations fully implemented and trained with staff. Training completed with assigned CNA 7-11-13. Nursing care plan for falls is in place for resident 76.</p> <p>Protocol for assessment after a fall with head injury has been revised to include specific head to toe assessment, vital signs and revised neuro checklist to be completed per guidelines and completed.</p> <p>Nurse for client 76 during fall 7-11-13 was trained prior to her next scheduled shift. Nursing staff has been trained.</p> <p>A fall assessment has been implemented to be completed after any fall by CNA/Designee and has been trained with staff.</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  07/22/2013
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>small laceration to the bridge of her nose and a bump on her forehead.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 7:20 AM and 7:45 AM. Client #76 was lying in her bed in her bedroom when LPN (Licensed Practical Nurse) #6 entered the client's bedroom to give client #76 her AM medications. Client #76 made verbal sounds. Client #76 had a hospital bracelet on her right wrist. LPN #6 was asked why client #76 had a hospital bracelet on and LPN #6 indicated the client was taken to the hospital on 7/8/13 to have staples removed from the back of her head due to an injury from a fall on 6/28/13. Client #76 had a quarter size hematoma on the back of her head. Client #76 turned her head toward the door, pointed toward the entrance door of her room and stated, "I fell." Client #76's abdomen was partially exposed with 2 greenish yellow bruises visible on her right lower quadrant of her abdomen, one the size of a quarter and the other a nickel. LPN #6 stated "I didn't know she had those."</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 9:45 AM through 10:00 AM. At 9:45 AM client #76 was seated in a chair facing the North window of her</p>		<p>Nursing including the one for resident 76 has been trained to notify ED and DNS/ANDS/Designee immediately following fall with assessment.</p> <p>Nurse for client 76 during fall 7-11-13 has been trained to call 911 when there is a head injury/trauma that is beyond a superficial abrasion prior to her next scheduled shift. Nursing staff trained on this as well.</p> <p>The fall assessment for resident 76 was by the IDT to assist in development or revision of the fall prevention/safe ambulation plan. QMRPs was trained to utilize the fall assessment in developing or revising the fall prevention/safe ambulation plan. QA will review procedures in place for supervision/monitoring individuals due to illness. Administrative, supervisory, nursing and CNA staff will be retrained on procedures for monitoring and providing services to individuals (a) ill but remaining in the facility (going to ER). Nursing will assess and determine safe supervision of an individual who is ill. Nurse will communicate this to CNA staff on a case by case basis.</p> <p>Nurse for resident 86 has been in-serviced on Wound Evaluation Flow sheet for pressure and</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  07/22/2013
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>bedroom. There were no facility staff in client #76's bedroom at 9:45 AM. Client #76 had a half-dollar, red, raised area located to left/center of her forehead above her left eyebrow. Client #76's raised area was covered with two steri strips which were saturated with dark red to black fluid. Client #76's forehead and hairline had dried dark red to black fluid. Client #76's index, middle, ring finger and thumb nails had dried dark red to black fluid under the fingernails. Client #76's left temple area was swollen, dark red to black in color. The bridge of client #76's nose, between her eyes, was swollen and colored dark red to black. At 9:50 AM CNA (Certified Nurse Aide) #1 entered client #76's bedroom. CNA #1 directed client #76 to use her walker and come to the unit program room. CNA #1 and client #76 exited the bedroom and the client walked to the unit program room without physical assistance or physical prompts from CNA #1. Client #76 then returned to her bedroom. Client #76's forehead was wiped with a wet tissue. Client #76's steri strips were not changed or cleaned.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 10:50 AM through 12:05 PM. At 10:50 AM client #76 was seated in a chair in the classroom. The client had</p>		<p>non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly.</p> <p>Nurse for residents sited have been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>Nurse for residents sited have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>Nurse for residents sited have been in-serviced to include clear, concise documentation when following a patient's plan of care. Nurse for resident 149 has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury.</p> <p>Re-positioning schedule for client #9 has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff.</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  07/22/2013	
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			
	a large hematoma (swollen area) the size of a quarter above her left brow near her nose. The hematoma had two steri-strips that were saturated with dried blood with a small amount of fresh blood oozing around the steri-strips. Client #76 had blood smeared on her forehead, across the bridge of her nose and on her fingers and one steri-strip across the bridge of her nose as well as abrasions above and around her left eye with noted bruising. CNA #1 was sitting at the table nearby client #76 and was asked what was on client #76's face. CNA #1 stated "That's blood where she fell and she keeps scratching at herself." CNA #1 put on gloves and attempted to wipe client #76's forehead with a disposable hand towelette. Client #76 pushed CNA #1 away while making crying sounds. CNA #1 stated, "Oh, she always does that when I touch her face. She don't like anybody touching her." CNA #1 was asked if client #76 had been offered an ice pack. CNA #1 stated, "No, no one has said anything about her using an icepack and I haven't seen her with one." The CNA indicated she had not been given any instructions from the LPN to offer client #76 an icepack. At 10:55 AM client #76 got up from her chair and walked to the bathroom in the activity room. Client #76 walked with an unsteady gait using a rolling walker. Client #76 set her walker		All clients who require the use of a sling including client 9 will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a care plan regarding sling usage for these clients. Staff will be inserviced All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart developed Medical Director has screened residents 1, 3 and 4's hearing and documented on their annual physical.  Nurse for client 2 will monitor vital signs and lung sounds each shift due to risk for aspiration due to emesis during seizures.  Resident 1 has a physician order that states Keppra may be crushed.  Resident number 23's orders have been reviewed to assure medication is given as prescribed.  Resident 2's nurse has been trained to review 15 minute check as documented by CNAs to assure it is completed properly.  II All residents of North Willow have the potential to be harmed				

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  07/22/2013	
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>outside of the bathroom and proceeded to go into the bathroom by herself. CNA #1 stated, "See, she always does that. We can't get her to use her walker and then she falls." CNA #1 opened the bathroom door to assist client #76. Client #76 had urinated on her clothing while in the bathroom and walked to her bedroom, using her walker and unassisted by the staff. CNA #1 followed client #76 to her bedroom and assisted client #76 to change her clothes. At 11:05 AM, after changing clothes, client #76 walked back to the classroom, again unassisted by the staff and sat in one of the chairs near the window. CNA #1 was asked if client #76 was able to communicate and to express when she was in pain. CNA #1 stated "For the most part, she can let you know when she's hurting, but not always." Client #76 was asked if she hurt or was in pain. Client #76 moved her head up and down and in a circular motion while smiling. Client #76 still had blood smeared on her forehead and across the bridge of her nose. CNA #1 again attempted to wipe client #76's forehead with a disposable towelette and the client pushed the staff away making a crying noise. A spot of blood was noted on client #76's right leg of her sweat pants that she was wearing. CNA #1 stated the spot on client #76's clothing was blood from the client's forehead. CNA #1 was asked if</p>		<p>by the deficient practice.</p> <p>III Nursing has been trained to implement level of supervision of ill residents, especially with regard to those going to ER and instruct CNA staff as to what level of supervision is to be given due to illness/injury. Nurses have been trained on Wound Evaluation Flow sheet for pressure and non-pressure wounds. It will be initiated when any new wound is identified and a wound progress note will be charted weekly. Re-positioning schedule those who need repositioning has been developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Annually at time of physical Medical Director or other physician who performs annual physical will screen and document hearing for each resident. North Willow now has a policy that identifies this screen as our practice. Any issues with the screen and the physician may refer resident to Audiologist. Nursing has been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>Nursing has been in-serviced to have all drugs and biologicals</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  07/22/2013	
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>she had reported the continued oozing of blood from the injury to the nurse. CNA #1 stated, "No." CNA #1 indicated the nurse and/or the QIDP (Qualified Intellectual Disabilities Professional) had not given the staff any specific guidance of how to supervise and/or assist client #76 in regard to falls. At 11:35 AM LPN (Licensed Practical Nurse) #1 approached client #76 and asked the client, "Hey, you alright?" Client #76 did not respond and the nurse left the classroom and returned with a small cup of water and offered it to client #76. Client #76 pushed LPN #1's hand away and refused the water. LPN #1 stated, "OK" and left the room. Client #76 began rubbing her forehead and left eye.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 2:35 PM through 2:50 PM. Client #76 was laying asleep in her bed.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 2:40 PM through 2:45 PM. Client #76 was laying asleep in her bed. No changes noted in the steri-strips. Client #76's face presented with streaks of dried blood across her forehead, nose and left eye. More bruising was noted around the orbit of her left eye. The steri strip across the bridge of her nose was in place. Client #76's nose was crooked and</p>		<p>locked inside medication cart when they are not preparing for administration.</p> <p>DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis.</p> <p>Nursing has been in-serviced to include clear, concise documentation when following a patient's plan of care. Re-positioning schedule for clients who need them were developed to provide alternate positioning q 2 hours and provide documentation of each repositioning</p> <p>Re-positioning schedule or position plans have been reviewed by IDT and/or PT/OT will be implemented and documented by direct care staff. All clients who require the use of a sling for transferring will be evaluated for the appropriate size sling and how to safely position the sling. Nursing services will complete a a care plan regarding sling usage for these clients. Staff will be inserviced</p> <p>All staff will be inserviced on guidelines regarding how and when to reposition clients who are in wheelchairs or are in bed, as well as on how to document the repositioning. Other clients who have a need to elevate their legs will have a similar chart</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  07/22/2013
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>appeared more swollen than when observed earlier in the day.</p> <p>Throughout observations, client #76 did not have nor was she offered an ice pack.</p> <p>Client #76's record was reviewed on 7/11/13 at 1 PM. Client #76's nursing notes indicated:</p> <p>__ On 4/18/13 the client took a few steps toward the trash can to throw trash away without the use of her walker and lost her balance and fell onto her buttocks.</p> <p>__ On 6/28/13 client #76 lost her balance as she was walking towards her room with her walker and fell backwards hitting the back of her head on the corner of the door frame. "Resident had cut and bump that was bleeding to back of head upon assessment. BP (Blood Pressure) 167/95, P (Pulse) 88 R (Respirations) 18. O2 (blood oxygen level) 98% on room air. Resident cried momentarily but was still alert and oriented. Resident sent to ER (Emergency Room) and came back with staples to back of head."</p> <p>__ On 6/29/13 "Client rested through the night. Noted with 4 staples upper left back of head, dry intact, no s/s (signs and/or symptoms) of infx (infection). At 2 AM BP 162/64, P-81, R-18... Neuro checks wnl (within normal limits)."</p> <p>__ On 7/6/13 The nurse did her monthly body assessments and noted client #76</p>		<p>developed</p> <p>Nurses for residents who have emesis during seizures will monitor vital signs and lung sounds each shift due to risk for aspiration.</p> <p>Residents who are prescribed Keppra and need their medication crushed now have an order that states Keppra may be crushed.</p> <p>Residents who take medications have had their orders reviewed to assure medication is given as prescribed. Nursing has been retrained on giving medication as prescribed.</p> <p>Updated Do Not Crush List is located in each MAR. Nurses have been trained to review 15 minute check as documented by CNAs to assure it is completed properly.</p> <p>IV Client Advocates will review fall procedure application as part of investigation to assure consistent application. Follow up for supervision will be completed by the Program Director/Designee in conjunction with the DNS/ADNS and HRC Director. DNS/ADNS/DCE or designee will implement Medication Lock Audit form to be monitored on a weekly basis. Active Treatment audits completed by QMRPs and</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 07/22/2013
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>had old bruising to her upper back. Bruises were yellow in color and starting to fade.</p> <p>__ On 7/8/13 the staples to the back of the client's head were removed.</p> <p>__ On 7/10/13 a floor mat for fall prevention was removed.</p> <p>__ On 7/11/13 at 9:55 AM, at 7:15 AM, "Client fall occurred today at 7:15 am while ambulating with walker to the bathroom stumbled and fell face first. Has an area raised to forehead open area small v shape gash measuring 3 cm x 3 cm on each side. And skin tear to bridge of nose. Steri strips applied to forehead and bridge of nose. Tylenol admin (administered) as ordered for discomfort. V/S (vital signs): 96.2 [temperature], 195/133 [blood pressure], 19 [respirations], O2 98 [Oxygen Saturation in the blood]."</p> <p>"[Name of doctor] informed, family notified and DON (Director of Nursing)/ED (Executive Director) made aware of client status."</p> <p>__ On 7/11/13 at 2:13 PM indicated "Neuro checks completed at 7:15 AM, 9:15 AM, 10 AM, 12 PM, 1:15 PM. Client was seen by [name of doctor] at 1 PM advise nursing that client did not need to be sent out to ER. Steri strips intact scant blood noted...."</p> <p>Client #76's BIRs (Behavior Incident Reports) indicated:</p>		<p>transfer observations will include proper sling use.</p> <p>DCE/DNS/ADNS will audit care plans for those using slings at least quarterly. Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Nursing to audit 15 minute checks each shift to ensure documentation. QMRP to audit daily to assure 15 minute documentation.</p> <p>Corrections to be completed by August 21, 2013.</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  07/22/2013	
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>__7/11/13 at 7:40 AM, client #76 was sitting in a chair in her bedroom when the staff prompted the client to go to the bathroom to get ready for breakfast. The report indicated client #76 was walking to the bathroom "then fell face forward on the floor." The report indicated the staff assisted the client up and to sit in the chair and then notified the nurse.</p> <p>__7/11/13 at 7:15 AM, "Client had fallen, nurse was doing assessment. Client was getting aggressive with staff while taking B/P. Caused B/P to be high."</p> <p>__7/11/13 at 7:15 AM client #76 was given an ice pack for her forehead 5 times.</p> <p>__7/11/13 at 9:45 AM client #76 was picking at her forehead and picking at her bandages after a fall. Nurse was notified that client was picking at forehead.</p> <p>__Client #76's Neurological Assessment form of 7/2013 in regard to the fall of 7/11/13 indicated LPN #1 had conducted a neurological assessment on client #76 on 7/11/13 at 7:15 AM, 9:15 AM, 10 AM, 12 PM, 1:15 PM and 7:30 AM. The form indicated at 7:15 AM client #76's BP was 195/133, at 9:15 AM 132/46, at 10 AM 192/33, at 12 PM 135/45, at 1:15 PM 138/56 and at 7:30 AM 142/89. When this surveyor asked LPN #1 for this information at 3:15 PM, LPN #1 indicated she had not documented all of</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  07/22/2013
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>the assessments and would have to document before she could give copies. LPN #1 then proceeded to add to the Assessment forms the assessments for 7/11/13 at 1:15 PM and 7:30 AM.</p> <p>__ Client #76's Neurological Assessment forms of 6/2013 in regard to the falls of 6/6/13 and 6/28/13 indicated the client's neurological assessments were conducted once a shift for 72 hours.</p> <p>A copy of the 7/11/13 fax to the facility doctor was provided to this surveyor by the DON (Director of Nurses). The note indicated a fax was sent from the facility at 7/11/13 at 9:16 AM to the facility doctor. The fax indicated "Client (#76) has had 3 falls in the last 30 days, 2 occurred within the last 7 days of each other. Client fall occurred today at 7:15 am while ambulating with walker to the bathroom stumbled and fell face first. Has an area raised to forehead open area small v shape gash measuring 3 cm (centimeters) x 3 cm on each side. And skin tear to bridge of nose. Blood noted to both area minimal (sic)."</p> <p>Client #76's 7/11/13 (no time documented) physician's progress note indicated client #76 had experienced a fall causing a "v" shape laceration on her mid-forehead. The note indicated</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  07/22/2013	
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>"Forehead as (sic) a soft tissue swelling with surrounding redness - especially over left forehead side. There are smaller areas of redness noted over nose.... Pupils are equal in size and eye movements are synchronized. There is dried blood overlying the laceration. Patient is noted to be alert to light, sound, voice and at her normal mental state. She is moving all extremities well and her balance is back to normal. Patient's BP was reported to be around 190 systolic after the injury but returned to a systolic around 140 after 20 minutes or so according to her nurse. Patient appears to have suffer (sic) no serious injury to intracranial area, but will send to ER (Emergency Room) to assure she is normal for her."</p> <p>Client #76's risk plan of 10/12/12 for falls indicated client #76 is "At risk for injury from falls or mobility trauma related to possible bone marrow suppression as a result of hypocalcemia as side effect of Depakote." The plan indicated the staff were to encourage client #76 to slow down when walking, wear proper fitting shoes and to be aware of her surroundings. The plan indicated the staff were to encourage client #76 to use her walker and to pay attention to her surroundings when ambulating and the staff were to provide stand by assistance while exercising. Client #76's risk plan</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 07/22/2013	
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>indicated no revisions or updates due to the client's recent falls in April, June and July.</p> <p>Client #76's ISP (Individualized Support Plan) of 11/1/12 indicated client #76 ambulated with independence via a wheeled walker and was at risk for falls. The ISP indicated a physical therapist saw client #76 on 10/30/12 which "revealed [client #76] tends to forget her forward wheeling walker and ambulates to short distances. Needs supervision for toileting and maximum verbal cues to use her walker."</p> <p>Client #76's IDT (Interdisciplinary Team) notes indicated:            ___ On 4/26/13 the IDT reviewed client #76's fall on 4/18/13 when she lost her balance as she was taking her dinner plate to the cart. No specific changes were made to her plan of care.            ___ On 6/12/13 the IDT reviewed client #76's fall in the dining room during church service on 6/7/13. The staff reported client #76 was walking and tripped on a chair and fell, hitting her head on another chair and sustaining a small cut on the bridge of her nose and a bump on her forehead. The team indicated it was an accident and the staff were directed to ensure that any tripping hazard that might impede safe movement of the</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  07/22/2013	
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>client be removed.</p> <p>__On 7/9/13 IDT notes indicated client #76 was sent to the hospital ER on 6/28/13 due to a fall she had in her bedroom. Client #76 was walking with her walker into her bedroom when she fell as she turned around hitting her head on the door frame resulting in lacerations to the back of her head. As a result, the client was treated and released with staples to the laceration. The IDT made no further recommendations and/or changes to the client's plan of treatment/care.</p> <p>Client #76's ISP/record did not indicate any revisions by the IDT (Interdisciplinary Team) due to client #76's falls in April, June and July to ensure client #76's safety due to falls with injury.</p> <p>Client #76 was interviewed on 7/11/13 at 9:45 AM. When asked how she injured her head, client #76 stated, "... fell."</p> <p>CNA #1 was interviewed on 7/11/13 at 9:50 AM. CNA #1 indicated client #76 had fallen the morning of 7/11/13. CNA #1 indicated client #76's forehead was injured.</p> <p>During interview with CNA #12 on 7/11/13 at 11:20 AM in the 2 West</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  07/22/2013	
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>classroom where client #76 was sitting, CNA #12 was asked how the staff were to supervise and/or monitor client #76 and had there been any recent changes/directions and/or training in regard to client #76 in regard to her falls and head injury. CNA #12 stated, "Oh, I don't know. She's not my person." At the time of the interview CNA #1 had stepped out of the room to assist with another client and CNA #12 was alone in the classroom with client #76 and 4 other clients.</p> <p>Interview with CNA #1 on 7/11/13 at 11:50 AM indicated nursing staff and/or programming staff had not provided or informed the direct care staff in any changes in client #76's care and/or in the level of supervision the staff were to provide client #76 to ensure her safety due to recurrent falls.</p> <p>__ Interview with the facility physician on 7/11/13 at 12:30 PM indicated he had not been notified of client #76's fall on 7/11/13 at the time of the interview.</p> <p>__ Interview with the facility DON (Director of Nurses) on 7/11/13 at 1:40 PM indicated whenever there was a client fall with an injury and/or head injury, the facility nurse was to notify the DON. The DON stated she had not been notified of</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  07/22/2013
--	---	--	---

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>client #76's fall and head injury at the time of the incident and the LPN "should have called me. I'm not sure why she didn't. She usually does." The DON indicated the nurse should have taken client #76's blood pressure again, called the doctor and if she couldn't reach the doctor, the nurse should have sent the client to the emergency room for an evaluation due to the elevated BP and head injury. The DON indicated the blood pressure machine could have been faulty and the nurse should have repeated the client's blood pressure after getting a reading of 195/133. When asked what was the facility policy and practice of care in regard to clients with head injuries, the DON stated the facility practice was for the nurses to do a neurological assessment "at least once a shift." The DON stated, "But as a nurse, I know it is more frequent and we usually do neuro assessments every 2 or 3 hours for the first 72 hours after an injury, we always do them more often."</p> <p>CNA #1 was interviewed on 7/11/13 at 2:41 PM. CNA #1 stated, "I was working with [client #76] this morning when she fell. I was standing at [client #76's] bed while she was using her walker to go to the restroom. I looked up and [client #76] was laying with her face on the floor in front of her restroom. There was blood</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  07/22/2013
--	---	--	---

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>splattered on the walls and all over the floor." CNA #1 stated, "I saw the amount of blood. So, I called the other CNA, [CNA #2], and the nurse, [LPN (Licensed Practical Nurse) #1]. [CNA #2] came and helped me get [client #76] up. [LPN #1] came in and helped look at [client #76]." When asked if LPN #1 had given her any instructions regarding how to monitor client #76's head injury, CNA #1 stated, "No, no one gave us any instructions." CNA #1 indicated client #76 was asleep in her bed. CNA #1 stated, "[Client #76] laid down around 1:15 PM. [Client #76] just fell asleep about 20 minutes ago."</p> <p>Interview with LPN #1 on 7/11/13 at 2:50 PM indicated after client #76's fall she took the client's vital signs and did a neurological assessment. LPN #1 indicated client #76's blood pressure reading after the fall was 195/133. LPN #1 stated the client was "combative" and she had difficulty taking her blood pressure, "So that's why it was probably so high." When asked if she had retaken client #76's blood pressure she indicated she had. When asked when and was it documented, LPN #1 stated "about 15 or 20 minutes later" but did not indicate what the client's blood pressure was and had not yet documented her results. When asked if she had notified the physician and/or consulted with anyone in regards</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  07/22/2013	
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			
	to client #76's head injury, elevated blood pressure and the possible need for further assessments and/or being sent for an evaluation due to head trauma, LPN #1 stated she telephoned the physician's office "around" 7:30 AM but no one answered the phone and she had sent a fax to the physician, but the fax machine wasn't working correctly. LPN #1 indicated she had not notified the DON. When asked if the staff should have reported to her the client's injury on her forehead was still bleeding, the LPN indicated yes and the staff had not said anything to her. When asked what was the facility policy/protocol for head injuries in regard to monitoring the client and what the staff should be monitoring, the LPN stated, "I didn't know we had a policy or anything to do with head injuries." LPN #1 indicated she had not given the staff any additional and/or specific instructions in regard to client #76's head injury and how the staff were to monitor client #76, the level of activity client #76 was to be involved with, if and when client #76 was to lay down and what the staff were to report to her. After interviewing LPN #1, the LPN was asked for documentation of her physical assessments and paper work of client #76. The LPN indicated she had not documented all of the information as she did not have time. This surveyor observed						

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  07/22/2013
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>this nurse completing her documentation of the 1:15 PM and 7:30 AM neuro assessments onto the Neurological Assessment form and completing the BIRs for 7/11/13 at 3:15 PM.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1 and PD (Program Director) #3 on 7/11/13 at 5:25 PM indicated there had been no specific changes made to client #76's ISP in regard to client #76's falls and/or how the staff were to supervise and/or monitor client #76 to protect client #76 from recurring injury due to falls. The PD #3 indicated the client was last assessed by PT (Physical Therapy) on 10/30/12. The PD #3 stated "I was going to have her reassessed after this last fall with injury." When asked why the client was not reassessed after the fall with injury in June, the PD indicated the client should have been seen by PT and was not sure why she wasn't.</p> <p>2. Observations were conducted on 7/8/13 at 4:30 P.M. Client #86 was asleep in his bed laying on his back with his shoulders flat against the mattress. There were two pillows beside him one on each side, the pillows were not placed underneath his body. The 15 (fifteen) minute check sheet for 7/8/13 was last initialed by staff at 1:45 P.M.</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  07/22/2013	
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>Observations were conducted on 7/9/13 at 7:05 AM. CNA #14 was in the bedroom with client #86 and his roommate. While CNA #14 was in room with client #86, CNA #14 pulled back the covers and exposed client #86's buttocks. Client #86 had a stage II pressure ulcer to his right buttocks the approximate size of a nickel, 2.1 cm in diameter. The client's buttocks were covered in a white heavy cream except for the area of the ulcer. CNA #14 stated, "He has one on the other side too, but it's hard to keep him off that side and his back." The CNA stated the ulcer to the left side "Is healed up I think."</p> <p>Observations were conducted on 7/9/13 from 1:05 P.M. until 1:54 P.M. Client #86 was in his bed lying on his back with his shoulders flat against the mattress. There were two pillows at his sides, but the pillows were not placed underneath his body. Staff did not enter or exit client #86's room during the observation.</p> <p>Client #86's record was reviewed on 7/10/13 at 3 PM. Client #86's nursing notes in regard to skin assessment and breakdown indicated:          __6/13/13 at 10:38 PM by an LPN, "old sore opening to buttocks. Physician and responsible party notified."          __6/14/13 at 7 AM by an RN, "Noted</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  07/22/2013	
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>with superficial open area, right buttock x1, left buttock x1. no s/s (signs or symptoms) of infx (infection). Client repositioned on sides during noc. N.O.'s (no orders) rec'd (received) per [name of facility doctor]. Keep patient off buttocks so areas can heal; cleanse open areas with soap/water after each incontinence change; apply [name of ointment] to wounds after each cleansing of wounds until healed."</p> <p>__6/14/13 at 10:58 AM by an LPN, "buttocks open in the crease/upper buttocks open."</p> <p>__6/15/13 at 11:27 PM by an RN, "[Name of ointment] and barrier cream applied to the buttocks area of the client. Skin openness to the Rt (right) buttock is dry with no discharge noted. Turned and repositioned as ordered. Will keep on monitoring."</p> <p>__6/16/13 at 5:41 AM by an RN, "Turned and repositioned for an openness to the right buttock."</p> <p>__6/16/13 at 7:41 PM by an RN, "Turned and reposition caring for an openness to the right buttock. Tx (treatment) done to the area."</p> <p>__6/20/13 at 6:34 AM by an LPN, "Area on buttocks assessed and dressing is clean and dry."</p> <p>__6/21/13 at 2:42 AM by an LPN, "Drsg (Dressing) to right buttocks clean, dry and intact."</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  07/22/2013
--	---	--	---

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>__6/22/13 at 7:05 AM by an LPN, "Area on buttocks assessed and dressing is C/D/I (clean/dry/intact)."</p> <p>__6/23/13 at 9:42 AM by an LPN, "[Name of dressing] on and intact to buttock. Changed 6/22/13 - old one fell off during bathing. Area is closing, decreased in size and dry."</p> <p>6/24/13 at 2:32 PM "[Name of dressing] applied to clients R (right) buttock. Area cleaned and dry."</p> <p>__6/25/13 at 7 AM by an RN, "Dressing clean, dry, intact on right buttock area."</p> <p>__6/28/13 at 3:14 PM "Turned q (every) 2 hrs (hours). Remains C/D (clean and dry). Drsg on and intact."</p> <p>__6/29/13 at 1:22 PM by an LPN, "Drsg (dressing) applied to coccyx scant amt (amount) of blood noted on old drsg. Tolerated change well. For the last two day shifts client had low grade temp. New order received for CXR (chest xray). [Name of mobile x-ray] arrived and done CXR results pending."</p> <p>__6/30/13 at 5:47 AM by an RN, "Open area to the buttock cleaned and a dressing placed."</p> <p>__7/3/13 at 10:34 PM by an LPN, "Multiple opening at buttocks."</p> <p>__7/4/13 at 7:12 AM by an LPN, "Residents skin was assessed (head to toe); skin was clean, dry, and intact; with excoriated (red) area still present on his buttock area (tx applied to area and</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  07/22/2013
--	---	--	---

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>resident has a N.O. (new order) for ATB (antibiotic) due to area."            ___7/5/13 at 7:08 AM by an LPN,            "Resident still has dressing to buttock area and it is C/D/I. Resident is still on ATB tx with no complaints noted or reported."            ___7/5/13 at 10:23 PM by an RN,            "Resident continued to have some watery stools on this shift most of the time until the end when it lowered. MD (doctor) notified and resolved to have all laxatives D/C'd (discontinued) temporarily until Monday next week. NO (new order) included to apply thick barrier cream skin protectant to the buttocks and perineal areas at every cleans (cleaning) until healed.... to D/C [name of dressing]."            ___7/5/13 at 10:30 PM by an LPN,            "Resident was turned every 2 hrs, cleaned and applied barrier cream each time to the buttocks and peri area. Skin area remains open and dry. Stayed undiapered throughout to airate (sic) the area."            ___7/6/13 at 7:09 AM by an LPN, "He [client #86] is still on 15 in (sic) checks and barrier cream was applied to area on buttocks."            ___7/6/13 at 7:18 AM by an LPN,"Residents skin was assessed (head to toe) skin was clean, dry and intact with no new open or bruised areas noted."            ___7/6/13 at 1:12 PM by an LPN, "... briefs open to help air out buttocks. Client</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  07/22/2013
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>turned q 2 hours."            __7/7/13 at 6:56 AM by an RN, "Client remains on ATB therapy for wound infection to the coccyx...."            __7/8/13 at 6:27 AM by an RN, "Client remains on ATB therapy for wound infection to the coccyx, no adverse reaction noted at this time, check, turn, and reposition every 2 hrs and as needed."            __7/8/13 at 1:21 PM by an LPN, "Client continues to be repositioned at every 2 hours. Treatment to the coccyx done at this time."            __7/9/13 at 6:06 AM by an LPN, "Continues ATB for Cellulitis without any adverse s/s (signs/symptoms) noted."            __7/9/13 at 7:51 PM by an LPN, "Remains on ATB therapy for cellulitis, no adverse reaction noted at this time."            __7/10/13 at 2:43 PM by an LPN, "...continues on ATB with no adverse reaction, treatment to buttocks done per orders."</p> <p>Client #86's nursing notes did not indicate a full and complete assessment of client #86's ulcerations to his buttocks. The client's nursing notes did not indicate the size, depth and/or staging of the client's ulcerations on his buttocks and failed to track the exact measurements of the ulcerated areas.</p> <p>Client #86's physician's progress notes for</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  07/22/2013	
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>2013 indicated:</p> <p>__7/4/13 "Patient with stage II ulcerations along... sacral (bony area at base of spine) area. Will apply [name of dressing] to these ulcerations to help with healing and to turn patient q (every) 2 hours."</p> <p>__7/11/13 "Follow up on open area on interg - luteal sacral folds. The open area on the left has closed over completely and the one of the right has closed to only 'nickel size' area that is roughly 1/2 - 1/3 of the size last week."</p> <p>Client #86's risk plan/nursing care plans of 2/11/13 indicated:</p> <p>__7/4/13 Client #86 was at risk for pressure ulcers due to "Braden Score (a clinical tool used to assess risk of a client for developing pressure ulcers) 18 or bowel incontinence." The revised plan of 7/4/13 indicated interventions for pressure ulcer actual or at risk to be:</p> <p>"1) Complete Braden Scale per Living Center Policy. 2) Conduct weekly skin inspection. 3) Treatments as ordered. 4) Turning and repositioning schedule every 2 hours to keep patient off sacrum until ulcerations are healed."</p> <p>__6/17/13 Client #86 was at risk of alteration to skin integrity due to excoriation and ulceration of right/left</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  07/22/2013	
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>buttock. The plan indicated intervention for alteration to skin integrity to be:</p> <ol style="list-style-type: none"> <li>1) Administer meds as ordered.</li> <li>2) Apply pillows between the client's legs.</li> <li>3) Apply treatments as ordered.</li> <li>4) Keep clean, dry and intact.</li> <li>5) Notify doctor as needed</li> <li>6) Turn every 2 hours."</li> </ol> <p>Client #86's staff training of 7/4/13 indicated client #86 was to be turned side to side every two hours to keep him off his sacrum until the open areas are healed. The staff should provide thorough skin care after incontinent episodes and apply treatment as needed. The staff should report any signs and symptoms of infection such as swelling, redness, warm, discharge, odor. The staff should check client every 15 minutes to make sure area remains dry at all times.</p> <p>Client #86's staff training of 7/6/13 indicated for staff to be careful turning the client side to side in order to prevent any further skin breakdown. "Report any new abrasion to the nurse for assessment."</p> <p>Client #86's 15 minute checks sheet to ensure the client was clean and dry and positioned correctly indicated the staff did not do 15 minute checks on the</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  07/22/2013	
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>following times dates and times:</p> <p>__7/4/13 3rd shift from 10:15 PM - 6:15 AM</p> <p>__7/6/13 2nd shift at 2:15 PM, 2:45 PM, 3 PM, 3:30 PM- 6 PM, 6:30 PM, 7 PM - 7:30 PM and 8 PM to 10:15 PM.</p> <p>__7/6/13 3rd shift from 10:15 PM - 6:15 AM.</p> <p>__7/7/13 2nd shift from 2:15 PM - 2:45 PM, 3:15 PM, 3:30 PM, 4 PM, 4:15 PM, 4:45 PM - 5:15 PM, 5:45 PM - 6:15 PM, 7 PM - 7:30 PM and 8 PM - 10 PM.</p> <p>__7/8/13 1st shift 6:15 AM - 2:15 PM.</p> <p>__7/8/13 2nd shift 2:15 PM - 3:30 PM, 4 PM, 4:30 PM - 6:30 PM, 7 PM, 7:30 PM, 8 PM - 10:15 PM.</p> <p>__7/9/13 1st shift at 6:15 AM, 6:30 AM, 1 PM - 1:30 PM.</p> <p>__7/9/13 2nd shift from 2:15 PM - 3:15 PM, 5:15 PM - 7 PM, 8:15 PM - 8:45 PM, 9:15 PM, 9:30 PM and 10:15 PM.</p> <p>__7/10/13 1st shift from 8:30 AM - 9:30 AM, 12:30 PM, 12:45 PM and 2 PM.</p> <p>__7/10/13 2nd shift at 5:15 PM and 8 PM.</p> <p>__7/11/13 1st shift from 12:30 PM - 2 PM.</p> <p>Client #86's record indicated a 24 hour flow sheet for the staff to document the time and position client #86 was positioned in. The flow sheet for July was not done from 7/1/13 through 7/8/13 and the flow sheet had not been</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  07/22/2013	
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>completed by the 3rd shift for July 9 and 10, 2013. Client #86's record did not indicate a repositioning schedule flow sheet for June, 2013.</p> <p>The undated form "Wound Evaluation Flow Sheet" was emailed to this surveyor 7/17/13 at 2:16 PM from the DON. The flow sheet indicated wound evaluation was to be completed for each pressure and non pressure wound. The flow sheet was to be initiated when a new wound is identified and the information is used to update the client's plan of care. It is updated at least weekly, reviewing status/changes in wound from the previous week, updating MD and family. Steps for using form indicated:  <input type="checkbox"/> Use one form per wound  <input type="checkbox"/> Identify location utilizing the anatomical body forms.  <input type="checkbox"/> Gather any necessary equipment to assist with evaluation.  <input type="checkbox"/> Date when the wound was identified.  <input type="checkbox"/> Indicate the type of wound.  <input type="checkbox"/> Only pressure ulcers are to be staged - use NPUAP (National Pressure Ulcer Advisory Panel) guidelines.  <input type="checkbox"/> Wounds are to be re-evaluated at least weekly.</p> <p>The 7/5/13 Wound Evaluation Flow Sheet for client #86 was emailed to this surveyor on 7/17/13 at 2:16 PM. The</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  07/22/2013	
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>form indicated the client was assessed on 7/5/13 with 2 wounds on client #86's buttocks, one on each side of the coccyx. The form did not indicate the measurements of each wound. The form was signed by an LPN. The form indicated the client was assessed on 7/16/13 and the client had one wound on the left side of his coccyx that measured .9 cm x .7 cm 0 depth. The form was difficult to identify who assessed the client, whether RN or LPN. The clients record did not indicate a wound evaluation flow sheet was completed when client #86's wounds to his buttocks were first noted on 6/13/13. The flow sheet did not indicate client #86's wounds were assessed every week since the discovery of the wounds and did not include the depth of the wounds.</p> <p>An interview was conducted with certified nursing aide (CNA) #75 on 7/9/13 at 1:54 P.M. When asked about client #86's positioning in bed, CNA #75 stated, "He has been the right way all day. He is stiff and will move some. I had a pillow in front of him and one behind him. He had shifted some, but he was not on his back."</p> <p>An interview was conducted with LPN #11 on 7/9/13 at 1:55 P.M. When asked about client #86's position in bed, LPN</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  07/22/2013	
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>#11 stated, "I've been checking him all day. He has been positioned correctly all day."</p> <p>An interview was conducted with Qualified Intellectual Disabilities Professionals (QIDP) #4 and #1 on 7/12/13 at 12:35 P.M. The QIDPs stated, "He moves around, has spasticity. He is to be repositioned every two (2) hours, left side one time then right side the next. Using pillows to support him. The 15 minute checks are to make sure he is not wet, is comfortable, and make sure he is still on his side." The QIDPs indicated if client #86's shoulders had been flat on the bed then he had not been positioned correctly and should have been on one of his sides.</p> <p>Telephone interview with the DON (Director of Nurses) and the facility Adm (Administrator) on 7/16/13 at 10 AM indicated since receiving a new memo from their corporate facility, the LPNs did not document measurements and assessments of ulcerations. The DON stated "only" the facility RNs were to assess, gauge and measure skin ulcerations. The DON indicated the LPNs documented dressing changes and condition of the client in general but the RNs were to document weekly on skin ulcerations. The DON indicated she was</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  07/22/2013
--	---	--	---

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>unable to find the memo and/or directive that indicated only RN's could do wound assessments. The DON indicated client #86's ulceration began in June with excoriation to his buttocks and then with the irritation of liquid stools, client #86's plan was changed to include the 15 minute checks to ensure client #86's wounds were clean, dry and intact. The DON indicated the staff were to check client #86 every 15 minutes and to document they completed the checks on the 15 minute check sheets. The DON indicated the staff were to document every 2 hours on client #86's flow sheet, the position client #86 was moved to.</p> <p>3. A facility BDDS (Bureau of Developmental Disabilities Services) report of 6/16/13 reviewed on 7/9/13 at 1 PM indicated on 6/15/13 at 7:35 AM client #149 was "seated in wheelchair in 3 west hallway near the wall awaiting transfer to ER (Emergency Room) for evaluation and treatment of distended abdomen and signs of discomfort. [Client #115] left her unit and turned [client #149] over to the floor in his wheelchair. Staff redirected [client #115] to her unit and nursing administered first aid. Nursing called 911 due to laceration to head behind ear on [client #149]. [Client #149] was transferred to [name of hospital] for evaluation and treatment.</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  07/22/2013	
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 remains in patient at [name of hospital] at this time with diagnosis of pneumonia. He is also being monitored at [name of hospital] due to previous diagnosis of Functional Disorders of the Stomach.... Staff working with [client #149] on 2nd floor have received further training to NOT leave residents in hallway unattended...."</p> <p>The investigative report of 6/15/13 indicated the staff reported seeing client #115 walking down the west corridor towards client #149, and upon approaching him, throwing his wheelchair to the side. Staff and nurse report immediately intervening.... Laceration noted to left side of [client #149's] head. [Client #149] was transferred by EMS [Emergency Medical Services] after 911 was called due to head injury. Resident received 3 staples to left side of head...."</p> <p>Telephone interview with the DON and the Adm (Administrator) on 7/16/13 at 10 AM indicated clients are never to be left in the hallway unattended. The DON indicated nursing staff should have assigned a staff to stay with client #149 until he could be transferred out to the hospital for evaluation.</p> <p>4. Observations were conducted on the</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  07/22/2013	
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>West wing of the 2nd floor of the facility on 7/8/13 between 3:15 PM and 5:45 PM. During this observation, client #9 sat in a wheelchair. Client #9 did not reposition herself in the wheel chair. The staff did not assist client #9 to reposition herself while sitting in the wheelchair.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/9/13 between 6:10 AM and 8:30 AM. At 6:45 AM CNA #6 gave client #9 a complete bath with no assistance from the client. Client #9 lay on the shower table in a rigid position, rolling onto her side only when assisted by CNA #9. After competing client #9's bath, a hoyer sling was placed under client #9 and client #9 rolled onto the sling. CNA #6 and CNA #7, used the hoyer lift to lift client #9 up and place her into the wheelchair. Client #9 continued to sit on the hoyer sling the remainder of the observation.</p> <p>Client #9's record was reviewed on 7/12/13 at 3 PM. Client #9's ISP (Individualized Support Plan) of 10/25/12 indicated client #9 used a wheelchair for mobility and required staff assistance for all transfers. Client #9's "Q (every) 2 hour positioning chart" for July 2013 indicated the staff did not document client #9's position from 3 PM to 5 AM</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  07/22/2013	
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>on July 1, 2, 4, 7 and 8.</p> <p>Interview with CNA #6 on 7/9/13 at 7 AM indicated client #9 required complete staff assistance to do transfers. CNA #6 stated client #9 "can move some, but not much" but needed staff assistance to reposition herself.</p> <p>Telephone interview with the DON (Director of Nurses) on 7/16/13 at 10 AM indicated client #9 had a positioning schedule in place due to immobility and decreased skin integrity and the staff were to reposition client #9 every 2 hours. The DON indicated the staff then were to document client #9's positions on the "Q (every) 2 hour positioning schedule."</p> <p>5. Program Director #1 was interviewed on 7/8/13 at 4:00 PM. She indicated client #2 had been hospitalized today (7/8/13) due to elevated respirations and suspected pneumonia.</p> <p>Client #2's record was reviewed on 7/11/13 at 10:00 AM. A progress note dated 7/8/13 at 5:41 AM indicated, "called to look at client as he was breathing hard and fast...client felt warm to touch,...sent to [name of hospital] for eval (evaluation)."</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  07/22/2013
--	---	--	---

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>A progress note dated 7/8/13 at 2:15 PM indicated the client returned from the hospital at 9:30 AM and "post hospital assessment was not WNL (within normal limits). Background: Client has a HX (history) of pneumonia and seizures..." The progress note indicated "lung sounds on upper Rt (right) and middle Rt lobes have wheezing on exhale" and client #2 was sent back to the hospital for additional treatment.</p> <p>Progress notes dated 6/28/13, 6/17/13, 6/11/13, 5/15/13, and 5/1/13 indicated client #2 had seizures with emesis (vomiting).</p> <p>A 7/11/12 Swallowing Bedside Evaluation indicated on 7/2/12 "Patient's mother reported that he has no h/o (history of) dysphagia. He is on a mechanical soft diet with thin liquids at North Willow...She reported his aspiration pneumonia have (sic) always been due to aspiration of gastric contents during seizures. VFSS (video fluoroscopic swallow study) attempted 5/12, but did not cooperate." Clinical impression: "At risk for silent aspiration...recommended diet NPO (nothing by mouth)...Outcome Summary Given purees,...Gulping notes, which is concerning for poor bolus (food) control/premature spillage, which</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  07/22/2013	
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>increases risk for aspiration before the swallow...patient would benefit from VFSS prior to resuming P.O. (food by mouth)." There was no evidence in the record of a VFSS evaluation, and no evidence of IDT (interdisciplinary) discussion regarding the results and recommendations of the swallow study.</p> <p>Client #2's health care plan dated 6/11/13 for seizures "indicated monitor vital signs and report abnormal to physician." The health care plan did not address client #2's risk of aspiration due to emesis during seizures. Client #2's most recent dental examination was 12/6/10. There was no evidence in the record of a more recent evaluation of his dental status.</p> <p>RN (registered nurse) #7 was interviewed on 7/11/13 at 3:40 PM. She indicated client #2 had recently gone out to the hospital on 7/8/13 after seizure with emesis. She indicated client #2 had a history of aspiration pneumonia and she would check on a protocol to address his risk.</p> <p>The Director of Nursing (DON) was interviewed on 7/12/13 at 11:50 AM. She indicated client #2 did not have a current protocol in place to address his risk of aspiration pneumonia due to emesis during seizure, but did have a protocol to</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  07/22/2013	
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>elevate the head of his bed and seizure medication. She indicated client #2's temperature was taken and lung sounds were monitored, but there was no written protocol to address his risk for aspiration pneumonia. The DON indicated client #2 should have had a more recent dental examination and she would check on the status. No additional evidence was provided of an updated dental exam for client #5. The DON was unsure of what a VFSS examination was and indicated she would look for further follow up of the examination and of the recommendation for client #2's diet of NPO. No further evidence of follow up to client #2's swallow study dated 7/11/12 or of a health care plan or intervention to address client #2's risk of aspiration due to emesis with seizures prior to his admission to the hospital on 7/8/13 was provided.</p> <p>6. Client #5's record was reviewed on 7/11/13 at 8:44 AM. A 4/10/12 physician's note indicated client #5 had a history of breast cancer and was being seen for follow up after cancer treatment. A physician's progress note dated 8/23/12 indicated "stable right mammogram. Bilat.(bilateral) due 2/13...." There was no evidence of a mammogram completed in 2/2013 for client #5.</p> <p>The DON was interviewed on 7/15/13 at</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  07/22/2013	
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>11:30 AM and indicated there was no further evidence of follow up for client #5's mammogram.</p> <p>7. An observation was conducted on the first level of the facility on 7/8/13 from 2:30 P.M. until 6:25 P.M.. At 4:36 P.M., LPN #2 began administering client #1's prescribed oral medications. LPN #2 popped out client #1's Levetiracetam 500 mg (milligram) tablet (seizures), put it in a "First Crush" machine, crushed the medication and administered it to client #1. Review of the medication package and Medication Administration Record dated 7/1/13 to 7/31/13 indicated: "Levetiracetam 500 mg tablet..two tablets twice daily...Do not chew or crush." At 5:00 P.M., LPN #2 administered client #23's oral prescribed medications with a cup of pudding. Review of the medication package and Medication Administration Record dated 7/1/13 to 7/31/13 indicated: "Divalproex Sodium 125 mg capsule (seizures)...1 tablet twice daily...May sprinkle over food...Oyster Shell Calcium 500 plus Vitamin D 200 (supplement)...1 tablet twice daily...Take with food...Metoclopramide 5 mg tablet...1 tablet three times daily before meals."</p> <p>An interview with Registered Nurse (RN) #7 was conducted on 7/12/13 at 1:30</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  07/22/2013
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>P.M.. RN #7 indicated staff should follow the directions on the label and MAR as ordered. When asked who reconciles the medication labels, MAR and Physician Orders for medication administration, the RN stated "The nurses do." The nurse further indicated client #23's Metoclopramide should have been given at 4 P.M. before the other medications.</p> <p>8. A review of client #1's medical record was conducted on 7/11/13 at 9:30 A.M.. Client #1's record indicated a most current hearing evaluation/assessment/exam dated 3/9/11 which indicated a recommendation by the audiologist to return in 1 year. Review of client #1's record failed to indicate he had a follow up completed.</p> <p>A review of client #3's medical record was conducted on 7/11/13 at 2:00 P.M.. Client #3's record indicated a most current hearing evaluation/assessment dated 4/13/11 which indicated a recommendation by the audiologist to return in 1 year. Review of client #3's record failed to indicate he had a follow up completed. Further review of client #3's record indicated a most current dental exam dated 5/14/12 which indicated a recommendation to return in 6 months. Review of the record failed to indicate he</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  07/22/2013
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>had a follow up dental visit as recommended by the dentist.</p> <p>A review of client #4's medical record was conducted on 7/11/13 at 11:50 A.M.. Client #4's record indicated a most current hearing evaluation/assessment dated 2/22/11 which indicated a recommendation by the audiologist to return in 1 year. Review of client #4's record failed to indicate he had a follow up completed.</p> <p>An interview with the Director of Nursing (DON) was conducted 7/12/13 at 1:30 P.M.. The DON indicated there was no documentation in the clients' records to show the recommended follow up visits occurred.</p> <p>3.1-17(a)</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  07/22/2013	
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			
W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 2 of 15 sampled clients (clients #2 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of clients' health status and medical needs.</p> <p>Findings include:</p> <p>1. A review of client #4's record was conducted on 7/11/13 at 11:50 A.M.. Client #4's record indicated "Nursing Quarterly" assessments on 12/31/12, 3/22/13, and 6/5/13. No Nursing Quarterly was available for review before 12/31/12. Client #4's most current annual physical was dated 3/21/13. Client #4's 3/19/13 Individual Support Plan (ISP) indicated client #4's diagnoses included, but were not limited to, Infantile cerebral palsy and Arteriosclerosis of extremities unspecified. Client #4's 7/13 physician orders indicated client #3 received routine medications.</p> <p>An interview with Registered Nurse (RN) #7 was conducted on 7/12/13 at 1:30 P.M.. The RN indicated nursing</p>	W000336	<p>W336</p> <p>I Nurse for residents 2 and 4 now have updated nursing quarterlies and annuals.</p> <p>Health Information Audit report will be utilized to ensure that quarterlies and annuals are completed on time.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Nursing will be retrained on completing quarterlies and annuals on a timely basis.</p> <p>IV Health Information Management completes weekly audits that include nursing quarterlies and annuals, DCE, DNS, and ADNS follow up on deficiencies noted on these reports. To be completed by August 21, 2013.</p>	08/21/2013			

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  07/22/2013
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>quarterlies are completed every three months.</p> <p>2. Client #2's record was reviewed on 7/11/13 at 10:00 AM and included nursing assessments dated 5/7/13, 11/6/12, and 8/15/12. There were no assessments in the record between 11/6/12 and 5/7/13 and no evidence of the need for a medical care plan.</p> <p>The DON (Director of Nursing) was interviewed on 7/12/13 at 11:50 AM. The DON indicated she would check on additional nursing assessments for client #2. No additional evidence of nursing assessments was provided.</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  07/22/2013
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	
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 5 of 40 doses administered for clients #24, #71 and #72.</p> <p>Findings include:</p> <p>1. During observations of the medication pass on the second floor of the facility on 7/8/13 between 4 PM and 6:15 PM the following was observed: __At 4:10 PM, RN (Registered Nurse) #8 gave client #72 Zyprexa (an antipsychotic) 5 mg, Levetiracetam (an anticonvulsant) 500 mg and Calcium 500 mg with Vitamin D. RN #8 did not give client #72 Metformin HCL (to control blood sugar) 500 mg.</p> <p>During observations of the medication pass on the second floor of the facility on 7/9/13 between 7 AM and 8:35 AM the following was observed: __At 7:50 AM, LPN (Licensed Practical Nurse) #6 gave client #71 Vitamin D, Colace (a stool softener) 100 mg (milligrams), Tegretol (an anticonvulsant)</p>	W000369	<p>W369 I Nurse for residents sited have been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Nursing has been in-serviced on Medication Administration to ensure medications are passed without error.</p> <p>IV Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Corrections to be completed by August 21, 2013.</p>	08/21/2013	

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  07/22/2013
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>300 mg, Bethanechol Chloride (for urinary problems) 25 mg, Depakote (an anticonvulsant) 125 mg, 46 units of Lantus insulin and 2 units of Novolog insulin. LPN #6 did not give client #71 Simethicone (for gas), MOM (Milk of Magnesia) (for abdominal gas) and/or an Cosopt eye drops in the client's right eye.</p> <p>Review of client #71's and #72's MAR (Medication Administration Record) for July 2013 on 7/10/13 at 2:45 PM indicated:            __ Client #71 was to have the following medications every day at 8 AM:            Simethicone 80 mg, MOM 30 ml (milliliters) and Cosopt Eye drops, 1 drop in right eye at 8 AM.            __ Client #72 was to have Metformin HCL 500 mg every day at 4 PM.</p> <p>Review of client #71's physicians orders for July 2013 indicated client #71 was to have Simethicone 80 mg, MOM 30 ml (milliliters) and Cosopt Eye drops, 1 drop in right eye at 8 AM.</p> <p>Review of client #72's physicians orders for July 2013 indicated client #72 was to have Metformin HCL 500 mg every day at 4 PM.</p> <p>Interview with LPN #6 on 7/9/13 at 9 AM indicated client #71 was to receive his</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  07/22/2013	
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>medications as ordered by the physician and as indicated on the client's MAR.</p> <p>Interview with the DON (Director of Nursing) on 7/12/13 at 4 PM indicated nursing staff were to provided the clients their medications as ordered by the physician and as indicated on the clients' MARs.</p> <p>2. An observation was conducted on the first level of the facility on 7/8/13 from 2:30 P.M. until 6:25 P.M.. At 4:13 P.M., LPN #2 began administering client #24's prescribed oral medications. LPN #2 took 4 medication packages from the medication cart and popped each of the medications into a plastic cup. Review of the medication packages and Medication Administration Record dated 7/1/13 to 7/31/13 indicated: "Furosemide 20 mg (milligram) tablet (diuretic)...Ranitidine 150 mg tablet (stomach acid)...Spironolactone 100 mg tablet (high blood pressure)...Klor Con (potassium)." LPN #2 then returned the medication packages into the medication cart locked the cart and administered client #24 her medications. Client #24 then stated to LPN #2 "You forgot my white pill." LPN #2 then looked into the plastic cup and stated "Oh, I did." LPN #2 then walked out of the bedroom, unlocked the medication cart and took a medication out</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  07/22/2013
--	---	--	---

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>of a locked medication box and popped the medication into the plastic cup. Review of the medication packet and MAR dated 7/1/13 to 7/31/13 indicated: "Alprazolam .25 mg tablet (anxiety)."</p> <p>An interview with LPN #2 was conducted on 7/8/13 at 4:25 P.M.. LPN #2 stated "I'm sorry I should have made sure I had all of her medications."</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  07/22/2013
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	
W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview, the facility failed to assure all medications remained locked until ready for administration which affected 5 of 15 sampled clients (clients #11, #12, #13, #14, and #15) and 50 of 133 additional clients (clients #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) who lived on the third floor of the facility.</p> <p>Findings include:</p> <p>Observations of clients on the third floor was conducted on 7/9/13 from 5:16 A.M. until 8:55 A.M.. At 7:35 A.M., a medication card containing potassium chloride which belonged to client #135 was laying on top of a medication cart. This medication was not locked in a medication cart and was accessible to all clients (#11, #12, #13, #14, #15, #99, #100, #101, #102, #103, #104, #105,</p>	W000382	<p>W382</p> <p>I Nurse for residents sited have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Nurses have been in-serviced to have all drugs and biologicals locked inside medication cart when they are not preparing for administration.</p> <p>IV Medication Administration audit will be completed weekly through rotation of nurses by Nursing Administration. Corrections to be completed by August 21, 2013.</p>	08/21/2013	

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  07/22/2013
--	---	--	---

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>#106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147 and #148) living on the third floor of the facility, as the medication was left unattended. The unlocked medication card was pointed out by the surveyor to the facility's administrator who contacted the facility's Director of Nursing and had the medication locked in the medication cart.</p> <p>The facility's administrator was interviewed on 7/9/13 at 7:57 A.M.. The facility's administrator indicated it is the policy of the facility to have all medications locked until they are being prepared for administration.</p> <p>3.1-25(1)</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  07/22/2013	
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			
W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to maintain and teach 5 of 15 sampled clients (clients #4, #6, #7, #10, and #15) and 2 additional clients (clients #24 and #53) to use and make informed choices regarding their adaptive equipment.</p> <p>Findings include:</p> <p>1. Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #6 was in the class room. Client #6 was not wearing glasses. Staff did not prompt client #6 to wear her glasses.</p> <p>Client #6's record was reviewed on 7/11/13 at 1:50 P.M. Client #6's Individual Support Plan (ISP) dated 9/13/12 indicated client #6 had glasses prescribed, but refused to wear them. Client #6 did not have a goal to wear her glasses.</p> <p>2. Observations of the second floor north</p>	W000436	<p>W436 I Client 6 has been referred to the Optometrist, will be evaluated and recommendations followed. Client #7 has a gait belt and CNA staff have been retrained on his ambulation plan. Client #10 has her right footrest to her wheelchair. Client #53 has his eyeglasses and CNA staff have been retrained on his eyeglasses goal. Client #24 has her original wheelchair back with appropriate footrests. Client #24 also has a formal plan that has been trained with CNA staff regarding her schedule for leg elevation. Client #4's arm rest has been replaced. Client #15 has eyeglasses and a corresponding program to teach him to wear them.</p> <p>II All residents might be at risk for this deficient practice.</p> <p>III The IDT has audited all residents for adaptive equipment. Programs have been modified as appropriate. PT/OT have audited all wheelchairs and wheeled walkers to identify any maintenance needs or missing</p>	08/21/2013			

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  07/22/2013	
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>class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #7 was seated in a chair by the window. Client #7 repeatedly stood up and attempted to walk. Staff redirected him back to his chair each time he stood up. At 4:04 P.M. CNA #70 put a gait belt on client #7.</p> <p>Client #7's record was reviewed on 7/11/13 at 4:10 P.M. Client #7's ISP dated 2/5/13 indicated client #7 was to utilize a gait belt and staff were to assist him when ambulating.</p> <p>An interview was conducted with QIDP #2 on 7/12/13 at 12:09 P.M. When asked about the client's gait belt, QIDP #2 stated, "Yes, he is to wear a gait belt for ambulation." QIDP #2 indicated client #7 needed to remain seated due to a history of falling and elopement. QIDP #2 indicated client #7's elopement had greatly decreased as he was not as quick as he used to be.</p> <p>3. Observations were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #10 was seated in a pink framed wheelchair. The right leg and foot rest of the wheelchair were missing. Observations were conducted on 7/12/13 from 8:48 A.M. until 9:25 A.M. Client #10 was again seated in a pink framed</p>		<p>parts.</p> <p>IV Adaptive equipment will be reviewed during PD and QMRP Rounds and throughout active treatment observations completed three times per week. Additionally, night-shift CNA's will be documenting any missing and/or broken wheelchair parts on the wheelchair Cleaning Checklist completed weekly. All corrections to be completed by August 21, 2013.</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  07/22/2013	
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>wheelchair. The right leg and footrest of the chair were missing.</p> <p>An interview was conducted with the Program Director (PD) #3 on 7/12/13 at 12:10 P.M. PD #3 indicated client #10 should either have both legs of the wheelchair in place or both removed. PD #3 indicated client #10 self-propelled in the wheelchair using her feet and it would most likely benefit her to have both legs removed. PD #3 did not know why one of the legs of client #10's wheelchair was missing as it was a new chair.</p> <p>4. Observations of the second floor north class room were conducted on 7/8/13 from 3:20 P.M. until 5:18 P.M. Client #53 was in the class room. Client #53 was wearing his glasses. Observations were conducted on 7/9/13 from 7:01 A.M. until 8:17 A.M. Client #53 was wearing his glasses. Observations of the second floor north class room were conducted on 7/12/13 from 8:48 A.M. until 9:25 A.M. Client #53 was in the classroom. Client #53 was not wearing his glasses.</p> <p>Client #53 was interviewed on 7/12/13 at 9:10 A.M. Client #53 indicated he did not know where his glasses were. Client #53 vocalized to get the attention of CNA #71 to ask for his glasses. CNA #71 gave client #53 his glasses at 9:19 A.M., after</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  07/22/2013	
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>CNA #71 got them from the LPN.</p> <p>5. Observations were completed at the facility on 7/8/13 from 3:25 PM until 6:25 PM. Client #24 took a shower at 3:50 PM. At 4:20 PM, client #24 was in the program room adjacent to the back entrance to the facility's first floor playing solitaire on the computer while sitting in her wheelchair. At 5:20 PM, client #24 sat in the dining room. Her lower left calf was a dark purple color.</p> <p>During observation at the facility on 7/9/13 from 7:07 AM until 8:25 AM, client #24's lower legs were a light purple color as she sat in the dining room for breakfast.</p> <p>Program Director (PD) #1 was interviewed on 7/8/13 at 5:51 PM and indicated the purple coloration of client #24's legs was typical for client #24. She indicated client #24 was using her old wheelchair while her current wheelchair was being repaired. PD #1 indicated client #24's wheelchair would provide more elevation for her legs and feet when it was repaired. She indicated it was a 30 day wait for foot rests and client #24 was a diabetic which contributed to the issue of purple coloration of her legs.</p> <p>Client #24 was interviewed on 7/8/13 at</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  07/22/2013	
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>6:25 PM and indicated she was unable to move her left leg due to a car accident when she was 2 years of age. She indicated this was her wheelchair, but she was unable to get her legs elevated with the footrests in the wheelchair.</p> <p>Client #24 record was reviewed on 7/11/13 at 3:58 PM. A care plan dated 4/10/13 indicated client #24 had altered skin integrity related to an open lesion. The care plan indicated "non Weight Bearing while lesion heals on plantar surface of left heel...Client is to keep foot elevated...Bunny Boot to LT (left) foot until healed." Physician's orders dated 7/1/13-7/31/13 indicated "Client to have elevating leg rest on w/c.(sic) to keep feet elevated." A 6/5/13 note indicated client #24's wound was healed. A 6/28/13 progress note indicated "Both lower extremities are slightly edematous (fluid buildup), and Client is encouraged to elevate them while up in the wheelchair." A 11/12/12 Physical Therapy (PT) Screen Form indicated "Recc (sic) (recommend) a new footbox for her w/c (wheelchair) at this time due to instability in UE (upper extremities). L (left LE (lower extremities) keeps slipping out of leg rest posing risk for injury/skin breakdown. The leg rests are not aligned straight and have a valgus (outward) angle thereby risking Pt (patient) joint</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  07/22/2013
--	---	--	---

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>alignment/integrity/tightness..Recc a custom footbox (attached to leg rests) for improved safety and functional mobility...Pt c/o (complains of) B/L (bilateral) foot pedals swinging out and pt has to constantly adjust it throughout the day. She is currently waiting for an approval for a new foot box.... "</p> <p>An Occupational Therapy (OT) evaluation dated 4/2/13 indicated under Notable decline (Indicates PT need) that client #24 used a power wheelchair "for a long time...Faulty leg rest; waiting for a new foot box, leg rest and ...cushion," and comments included, "Awaiting on new w/c parts..." An Occupational Therapy Evaluation dated 4/18/13 indicated "She would highly benefit from elevating leg rests...L LE (lower extremity) has very poor circulation...Pt is to keep her legs elevated for periods during the day. She will benefit from elevating leg rests to decrease swelling and improve circulation...."</p> <p>Program Director (PD) #1 was interviewed on 7/12/13 at 12:40 PM. She indicated the wheelchair repairs had been delayed due to approvals by Medicare and Medicaid.</p> <p>6. Observations were conducted on the first level on 7/8/13 from 1:00 P.M. until</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  07/22/2013	
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>2:00 P.M. and again from 2:30 P.M. until 6:25 P.M.. During the entire observation period client #4 was observed sitting in his wheelchair. Client #4's left arm rest had black tape wrapped around it. When asked how long his arm rest had had the black tape on it, client #4 stated "For a while." When asked if it was longer than a month, client #4 shook his head up and down, indicating yes.</p> <p>A review of client #4's record was conducted on 7/11/13 at 11:50 A.M.. Review of client #4's 4/15/13 Occupational Therapy (OT) screen indicated: "Client wears right and left wrist splints all day to support his wrists due to impaired fine motor skills...both splints are worn and frayed. He will benefit from new ones. Size medium for right and left wrists."</p> <p>An interview with client #4's Physical Therapist (PT) was conducted on 7/12/13 at 1:00 P.M.. The PT indicated she did not know client #4's left arm rest had black tape wrapped around it. When asked if there was documentation to show client #4's wrist splints had been replaced, the PT indicated she would submit documentation. The PT left and did not return with documentation. No documentation was submitted to indicate client #4's wrist splints had been replaced.</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  07/22/2013
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. Client #15 was observed on 7/8/13 from 2:59 P.M. until 6:40 P.M., and on 7/9/13 from 5:16 A.M. until 8:55 A.M.. During both observation periods, client #15 did not wear eyeglasses, nor did CNAs #121, #123, #124, #177, #178, and #179 prompt or assist client #15 in wearing his eyeglasses.</p> <p>Client #15's record was reviewed on 7/11/13 at 8:03 A.M.. A review of the client's 4/29/13 Individual Program Plan indicated client #15 "refuses to wear eyeglasses." A review of client #15's 9/19/12 optometry exam indicated client #15 had eyeglasses to wear. Further review of 10/11/12 psychotropic treatment program indicated client #15 "declines the use of new corrective lenses."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #3 was interviewed on 7/11/13 at 2:37 P.M.. QIDP #3 indicated he was unaware client #15 was to wear eyeglasses.</p> <p>3.1-39(a)</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  07/22/2013	
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			
W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview for 15 of 15 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) and for 133 additional clients (clients #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148), the facility failed to promote a clean environment to prevent the potential for the spread of infection.</p> <p>Findings include:</p>	W000454	<p>W454 1. The Housekeeping Staff will complete a "Cleaning List" for the ice machine daily. The Housekeeping Supervisor will review the "Cleaning List" daily and report any ice machine maintenance issues to the ED immediately for repair. Housekeeping staff will be trained on the "Cleaning List."</p> <p>Steam table has been repaired. Staff for sited residents have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood. Sanitizing unit installed in kitchen for use between dirty side and hand sink. ADD/designee assures gloves are available for use in kitchen. Residents 107 and 148 have been assessed by their IDT as to individual interventions for drooling and those interventions are implemented. Dietary must follow the following procedure when going from dirty to clean side of kitchen.</p> <ol style="list-style-type: none"> <li>1. Wear gloves on dirty side</li> <li>2. to go to clean side, remove gloves and use hand sanitizer</li> <li>3. go to hand sink and wash</li> </ol>	08/21/2013			

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  07/22/2013	
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>1. On 7/10/13 at 8:15am, the third floor ice machine had finger prints on the outside of the machine. At 8:15am, the third floor ice machine had a dried brown substance on the outside of the dispensing arm, the bin grill (to prevent the retrieval of ice already dispensed) was missing, and a brown substance was inside the ice bin around the drain portion. From 8:15am until 9:10am, clients on the third floor were observed to approach the ice machine, obtain old already dispensed ice from bin with their fingers, and consume the ice or place it in their cups for use. At 8:15am, the ADD (Assistant Director of Dietary) indicated dietary staff were not responsible for the ice machines on first, second, or third floors for cleaning or maintenance of the ice machines.</p> <p>On 7/10/13 at 10:30am, on 7/11/13 at 12:35pm, and on 7/15/13 at 8am, the cleaning schedules and policy for the first, second, and third floor ice machines were requested from the ADD, the Director of Clinical Education, and the Administrator and no cleaning schedules or policy for ice machines on first, second, or third floors were available for review.</p> <p>2. On 07/10/2013 from 7:45am until 10:15am the following was observed with the ADD:</p>		<p>hands with soap and water rubbing for 20 seconds washing thoroughly 4. Dry hands, turn off water with towel and discard.</p> <p>Follow menu and provide foods as per guidelines. Do not mix foods together such as scrambled eggs and Banana bread. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff who was P-2 trained that it was his task to report and discard outdated food. When out of date food is found it will be discarded, report this to the ADD. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service. Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be served</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  07/22/2013
--	---	--	---

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>-At 7:45am, the ADD indicated clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148 had food, utensils, or supplies from the dietary department.</p> <p>-At 7:45am, the ADD and Dietary Staff (DS) #48 loaded the pans of food for the third floor on a cart. At 8:00am, the food arrived on the third floor for clients waiting for breakfast. At 8:00am, the ADD and DS #48 indicated the steam table was leaking and did not maintain a correct temperature for the food served. At 8:35am, DS #48 poured additional water into the steam table bin. The water</p>		<p>per North Willow policy.. Plastic barriers and other kitchen maintenance completed.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III. The Housekeeping Supervisor will complete a daily Checklist and report any maintenance issues to the ED immediately for repair. Housekeeping Supervisor will be trained on the Checklist. The QDDP or designee will complete "Infection Control" retraining with staff including issues that need to be addressed immediately, cleaning up after clients/ encourage clients to clean up after themselves, and how to report issues to cleaning services. The QDDP or designee will complete Environmental Rounds including observation of cleanliness of environment and personal appearance of clients, one time weekly and provide feedback to the staff at the time of the observation. Staff have been retrained to assist in cleaning up a resident who has blood or other matter that they need assistance in cleaning using proper precautions in cases of blood. Dietary employees were trained to use gloves on the dirty side of the kitchen, remove gloves when</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  07/22/2013	
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>made a hissing sound and water vapors rose up from the steam table bin beneath the food pans. DS #48 indicated the third floor steam table had been broken over 3 months and pointed to a two (2) quart container underneath which collected the leaking hot water. Water was observed to be leaking from the bottom of the table down into the two quart pan underneath the steam table. The steam table had a metal barrier between the front of the steam table bins and people walking by the steam table. This protective metal covering was missing the connecting screws which held the steam table covering over the food in place. This protective covering would move to expose space between the steam table bins of food and the space in front of the steam table.</p> <p>-On 7/10/13 at 9:15am, a food cart was observed inside the kitchen being prepared for the lunch meal. The doors of the cart were open, condiments on a tray were inside the food cart, and sixteen of sixteen (16/16) metal cart shelves were dusty and had food debris on them.</p> <p>-On 7/10/13 at 9:15am, the walk in freezer and refrigerator had torn plastic barrier dividers. The ADD indicated the existing plastic barrier dividers were stained and worn. At 9:15am, the kitchen</p>		<p>leaving dirty and going to clean side, using sanitizer, enter clean side and wash hands at hand sink prior to working on the clean side of kitchen. Recreation will utilize wipes for hand washing or assist resident as needed to wash their hands prior to touching equipment that is being used by multiple residents and their hands are soiled. Residents who drool have been assessed by the IDT as to their need for individual interventions to assist with maintaining sanitation around drooling. ADD to observe for procedure of glove use and hand sanitizing and hand washing. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff trained P-2 trained that it was his task to report and discard outdated food. Dietary staff trained to chart Dishwasher temperatures on log as required. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the</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 07/22/2013
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>mop sink had a hose that connected to the nozzle of the sink's water supply and rested the opposite end of the hose into the water reservoir to the sink. No check valve was observed on water supply used from the sink. The ADD indicated she was not aware of the use of check valves to prevent the backflow of dirty water into the clean water supply. The ADD indicated the dietary department used this sink every shift to empty mop water and refill their mop buckets for use.</p> <p>-On 7/10/13 at 9:20am, inside the kitchen reach in freezer were three (3) forty-eight ounces (48oz.) loaves of Cream Cheese which expired on 10/5/2012. The ADD indicated the Cream Cheese was expired and should have been removed from use.</p> <p>-On 7/10/13 at 10:00am, the spice shelves had an opened sixteen ounce (16oz.) bottle of Cinnamon Glaze which indicated "best by 7/2012," a 16oz. an opened bottle of Lemon Glaze which indicated "best by 4/2012," and the ADD picked up both items after they were identified then threw them both away into the trash.</p> <p>-On 7/10/13 at 10:00am, the dish washer temperature was 142 degrees Fahrenheit for the wash cycle and 170 degrees Fahrenheit for the rinse cycle. The Dish</p>		<p>proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be served per North Willow policy.. ED has observed ADD in inputting a work order in building engines to assure she understands and can input order.</p> <p>IV The PD will review the Environmental Round observations weekly and complete retraining as needed. ADD/Designee observes daily to assure glove use/hand washing procedure is followed properly in the kitchen. QMRPs have been educated to observe their caseload and when issues such as drooling occur, they must implement interventions to assist with the sanitation and dignity issues with it. Program Directors assure QMRP staff assess, develop and implement those interventions. ADD will check dishes to assure dry, assure that P-2 tasks are completed including checking for dates on foods to assure they are not out dated. ADD will input work orders in building engines. When work orders not addressed ADD refers to ED for follow up. ADD checks temperature log for dishwasher. ADD checks cleanliness of cart shelves. Corrections to be completed by August 21, 2013.</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  07/22/2013
--	---	--	---

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>Machine temperature log was requested for review and the ADD indicated she would provide it later. The ADD indicated the wash cycle should be 150 degrees Fahrenheit for the wash cycle and 180 degrees Fahrenheit for the rinse cycle.</p> <p>-On 7/10/13 at 9:30am, the three compartment sink had food debris in the drain and it was dried to each of the three bays in the sink. The ADD indicated the three compartment sink was not operational and could not be used. The ADD indicated the sink had been broken over one year.</p> <p>-On 7/10/13 at 9:30am, a liquid was observed between dishes stacked and stored as clean. The Ice Machine scoop was cracked, and stored in a plastic broken sleeve without a covering on the side of the ice machine in the food preparation area. On a cart stored as clean were four of four (4/4) pitchers stored upside down which had water draining from each of the pitchers onto the cart. The cart had food debris on the cart and under the upside down pitchers. There were two of five (2/5) Juice coolers that were stained and had a dark build up of a brown substance.</p> <p>An interview on 07/11/2013 at 3:00pm, the ADD indicated the wash cycle</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  07/22/2013
--	---	--	---

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>temperature was 150 degrees Fahrenheit and the rinse cycle was 180 degrees Fahrenheit. The ADD indicated the temperatures were checked and recorded after each meal, then added numbers to the "Dish Machine Temperature Log" before making a copy of the log. The ADD indicated the dishes are checked for cleanliness before they are put away.</p> <p>An undated policy, titled, "Damaged China and Glassware Surveillance" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...Damaged items are immediately taken out of service...."</p> <p>A 2011 policy, titled, "Dish Machine Use and Care" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...High Temperature machine, Wash - temperature must be maintained at a minimum of 150 F (degrees Fahrenheit) per state regulations during the wash cycle time. Rinse - Temperature must be maintained at a minimum of 180 (degrees) F per gauge...."</p> <p>3. Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 9:45 AM through 10:00 AM. At 9:45 AM client #76 was seated in a chair facing the North window of her bedroom. There were no facility staff in</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  07/22/2013
--	---	--	---

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>client #76's bedroom at 9:45 AM. Client #76 had a half-dollar, red, raised area located to left/center of her forehead above her left eyebrow. Client #76's raised area was covered with two steri strips which were saturated with dark red to black fluid. Client #76's forehead and hairline had dried dark red to black fluid. Client #76's index, middle, ring finger and thumb nails had dried dark red to black fluid under the fingernails. Client #76's left temple area was swollen, dark red to black in color. The bridge of client #76's nose, between her eyes, was swollen and colored dark red to black. At 9:50 AM CNA (Certified Nurse Aide) #1 entered client #76's bedroom. CNA #1 directed client #76 to use her walker and come to the unit program room. CNA #1 and client #76 exited the bedroom and the client walked to the unit program room without physical assistance or physical prompts from CNA #1. Client #76 then returned to her bedroom. Client #76's forehead was wiped with a wet tissue. Client #76's steri strips were not changed or cleaned.</p> <p>Observations were conducted on the West wing of the 2nd floor of the facility on 7/11/13 from 10:50 AM through 12:05 PM.</p> <p>At 10:50 AM client #76 was seated in a chair in the classroom. The client had a</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  07/22/2013
--	---	--	---

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>large hematoma (swollen area) the size of a quarter above her left brow near her nose. The hematoma had two steri-strips that were saturated with dried blood with a small amount of fresh blood oozing around the steri-strips. Client #76 had fresh blood smeared on her forehead, across the bridge of her nose and on her fingers. CNA #1 was sitting at the table nearby client #76 and did not get up. CNA #76 then got up and got disposable hand wipes and began wiping away some of client #76's fresh and dried blood on her face and hands.</p> <p>__At 10:55 AM client #76 got up from her chair and walked to the bathroom in the activity room. CNA #1 opened the bathroom door to assist client #76. Client #76 had urinated on a large part of the back of her clothing while in the bathroom. Client #76 walked to her bedroom and sat down in a straight chair near her bed. CNA #1 assisted client #76 to change her clothes. At 11:05 AM, after changing clothes, client #76 walked back to the classroom, sat down and leaned forward. A drop of blood dripped onto client #76's right leg of her sweatpants. CNA #1 did not prompt client #76 to change her clothing again.</p> <p>__At 11:05 AM, client #70 was sitting in a chair in the West wing classroom when he leaned over and spit clear mucous on the floor. CNA #12 was in the room at the</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  07/22/2013
--	---	--	---

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>time and observed client #70 spitting on the floor. CNA #12 stated, "Don't do that [client #70]." CNA #12 did not clean the floor. Several spill spots were on the floor that looked as if someone had spilled a drink. CNA #12 was asked what were the stains on the floor. CNA #12 stated, "I don't know, looks like somebody spilled something." CNA #12 did not clean the floor and/or notify cleaning services to mop/disinfect the classroom floor.</p> <p>Telephone interview with PD (Program Director) #3 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 7/16/13 at 11:30 AM indicated the staff were to immediately clean up spills and/or call housekeeping to assist if needed. PD #3 stated the staff "should have" cleaned/disinfected client #76's chair in her bedroom after sitting in it with urine soaked clothing. PD #3 indicated anytime a client had dried/fresh blood and/or body fluids on them, the staff were to immediately address the issue and clean/disinfect the area and/or items and prompt/assist the clients in cleaning themselves and changing clothes.</p> <p>3.1-18(a)</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  07/22/2013
--	---	--	---

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

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  07/22/2013
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	
W000455	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview for 15 of 15 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) and for 133 additional clients (clients #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) who lived in the facility, the facility failed to teach, encourage, and maintain personal hygiene practices for the prevention practices of infection control and a sanitary environment when opportunities existed.</p>	W000455	<p>W455 I Sanitizing unit installed in kitchen for use between dirty side and hand sink. ADD/designee assures gloves are available for use in kitchen. Residents 107 and 148 have been assessed by their IDT as to individual interventions for drooling and those interventions are implemented. Dietary must follow the following procedure when going from dirty to clean side of kitchen.</p> <ol style="list-style-type: none"> <li>1. Wear gloves on dirty side</li> <li>2. to go to clean side, remove gloves and use hand sanitizer</li> <li>3. go to hand sink and wash hands with soap and water rubbing for 20 seconds washing thoroughly</li> <li>4. Dry hands, turn off water with towel and discard.</li> </ol> <p>Follow menu and provide foods as per guidelines. Do not mix foods together such as scrambled eggs and Banana bread. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff who was P-2 trained that it was his task to report and discard outdated food. When out of date food is found it will be discarded, report this to the ADD. Dietary staff trained Dishwasher</p>	08/21/2013	

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  07/22/2013	
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>Findings include:</p> <p>1. On 07/10/2013 from 7:45am until 10:15am, the following was observed with the Assistant Director of Dietary (ADD):</p> <p>-At 7:45am, the ADD indicated clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148 had food, utensils, or supplies from the dietary department. From 9:15am until 10:15am, no dietary staff were observed to wash their hands. At 10am, the ADD indicated there was no hand sink</p>		<p>must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done.</p> <p>Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service.</p> <p>Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be served per North Willow policy..</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Dietary employees were trained to use gloves on the dirty side of the kitchen, remove gloves when leaving dirty and going to clean side, using sanitizer, enter clean side and wash hands at hand sink prior to working on the clean side of kitchen. Recreation will utilize wipes for hand washing or assist resident as needed to wash their hands prior to touching equipment that is being used by</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  07/22/2013
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>and no means for dietary staff to wash their hands in the dish room between the soiled side of the dish room to the clean side of the dish room. At 10am, the ADD showed the single handwashing sink in dietary located behind a barrier wall of the dish room and down the walkway to the corner of the dietary kitchen beside the ovens. The ADD indicated staff in the dish room used plastic gloves on the soiled side of the dish room then removed their gloves before entering the clean side of the dish room. No gloves were observed available for use.</p> <p>On 7/11/13 at 3:00pm, a review of the facility's policy and procedure 2011 "Handwashing" which indicated "Policy: Dining Services employees must keep their hands and exposed portions of their arms clean by washing hands and rinsing exposed portions of arms vigorously for a minimum of 20 seconds, paying particular attention to the areas underneath the fingernails and between fingers. Dining Services employees must effectively clean hands at appropriate kitchen hand sinks with proper cleaning compounds prior to handling, preparing, serving, and distributing food, working with clean utensils, dishes, and equipment...."</p>		<p>multiple residents and their hands are soiled. Residents who drool have been assessed by the IDT as to their need for individual interventions to assist with maintaining sanitation around drooling. ADD to observe for procedure of glove use and hand sanitizing and hand washing. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff trained P-2 trained that it was his task to report and discard outdated food. Dietary staff trained to chart Dishwasher temperatures on log as required. Dietary staff trained Dishwasher must wash at 150 degrees and rinse at 180 degrees . When you note it is not this hot, report immediately to ADD/ED so that repair can be done. Dietary responsible for charting Dishwasher temperatures trained to chart on log as required. Dishes must be clean and dry. Do not send wet dishes to the floor for service Dietary staff trained all equipment must be in good repair, report to ADD/ED when there is an equipment issue. Dietary staff trained food and drink must be served at the proper temperature. Hot foods are to be 140-150 degrees, cold food and drinks at 38-41 degrees. Measure temperature prior to taking food and drinks to the floor. Coffee should be served per North Willow policy.. ED has observed ADD in inputting a work order in building</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  07/22/2013
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	
	2. Client #107 was observed during the initial observation period on 7/8/13 from 1:14 P.M. until 2:03 P.M.. Client #107 was drooling excessively throughout the observation, wiping his chin with his hands. At 1:55 P.M., CNAs #12, #13, #14, and #15 prompted and assisted client #107 to throw bean bags at a board game activity. CNAs #12, #13, #14, and #15 did not prompt or assist client #107 in washing his hands prior to the activity.		engines to assure she understands and can input order.  IV ADD/Designee observes daily to assure glove use/hand washing procedure is followed properly in the kitchen. QMRPs have been educated to observe their caseload and when issues such as drooling occur, they must implement interventions to assist with the sanitation and dignity issues with it. Program Directors assure QMRP staff assess, develop and implement those interventions. ADD will check dishes to assure dry, assure that P-2 tasks are completed including checking for dates on foods to assure they are not out dated. ADD will input work orders in building engines. ADD checks temperature log for dishwasher. ADD checks cleanliness of cart shelves. Completed by 8-21-13.		

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  07/22/2013
--	---	--	---

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>Client #148 was observed on 7/8/13 from 2:59 P.M. until 6:40 P.M.. Client #148 was drooling excessively throughout the observation, wiping his chin with his hands. At 3:35 P.M., CNAs #121, #123, and #124 assisted client #148 to pass a ball around with a group of clients from the third floor. CNAs #121, #123, and #124 were not observed to prompt or assist client #148 in washing his hands prior to participating in the activity.</p> <p>Program Director #3 was interviewed on 7/11/13 at 2:22 P.M.. Program Director #3 indicated CNAs #12, #13, #14, #15, #121, #123, and #124 should have assisted or prompted clients #107 and #148 in washing their hands prior to participating in a group activity with other clients from the third floor.</p> <p>3.1-18(b)(1)</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  07/22/2013	
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			
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 3 of 15 sampled clients (#1, #4 and #9) and 1 additional client (#37), the facility failed to ensure clients received the recommended texture of their prescribed diets.</p> <p>Findings include:</p> <p>1. On 7/8/13 at 2:50pm, the facility's reportable incidents were reviewed and indicated the following for client #37.</p> <p>-A 2/25/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 2/24/13 at 2:00pm, indicated client #37 had gone out of the facility to church with staff and a group of clients. After church the group went out to eat at a local restaurant. The report indicated client #37 ordered a chicken sandwich, fries, coke, and a small milkshake. The report indicated "Staff with [client #37] cut the sandwich into quarters (size bites). [Client #37] took a few bites of her food and began to choke. The Heimlich was done, [client #37] coughed up several pieces of food onto her plate." The report indicated client #37</p>	W000460	<p>W460 I Resident 37 has had her dining plan reviewed, her dining goal reviewed. The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is listed on the form as well as instruction that if there is a change or any problem in staff attending, the supervisor will be contacted for direction. Dietary staff have been trained to follow menu and provide correct menued items for resident 9. Though staff are certain resident 4 received his regular diet, staff have been trained to assure resident 4 receives his prescribed diet. Resident 1's staff have been retrained to assure he receives his prescribed diet and double portions as prescribed.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III The Out Trip Form has been revised to include resident diets when food will be consumed on the trip, the form is taken on the trip for reference, staff to attend is listed on the form as well as instruction that if there is a change or any problem in staff</p>	08/21/2013			

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  07/22/2013	
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>was "on a mechanical soft diet" before the incident and the staff on the outing was suspended pending investigation.</p> <p>-A 3/4/13 Follow up BDDS report indicated client #37 was on a mechanical soft diet before the incident. The follow up report indicated the staff had cut up client #37's "grilled chicken" sandwich into quarters, client #37 consumed a "few bites," choked, staff initiated the Heimlich Maneuver with no results, a restaurant customer who was identified as a community Registered Nurse assisted with the Heimlich Maneuver, and the food was dislodged enabling client #37 to breathe. The staff involved with the incident was terminated from employment as the result of client #37 not having the correct food consistency.</p> <p>On 7/11/13 at 2:20pm, client #37's record was reviewed. Client #37's undated "Quick Diet Reference" from the facility's unit where client #37 lived, indicated client #37's name, "Mech. (Mechanical) soft" diet. Client #37's 7/10/13, 3/28/13, and 8/29/2011 "Physician's Order," and client #37's 3/12/13 "Nursing Assessment" indicated client #37 was at risk to choke and was to receive a mechanical soft diet. Client #37's 4/9/13 ISP (Individual Support Plan) indicated she was at risk to choke and was to</p>		<p>attending, the supervisor will be contacted for direction. Dietary staff have been retrained to follow menu and provide correct menued items. Staff have been retrained to provide prescribed diets including portion sizes.</p> <p>IV Out trip forms are reviewed prior to trips being taken to assure correct information is present and staff have been trained on the form and trip procedure. Dining monitors have been retrained to observe and ensure diets are checked by direct care staff and those diets are followed including portion sizes. Completed by 8-21-13.</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  07/22/2013	
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>receive a mechanical soft diet.</p> <p>On 7/11/13 at 9:50am, an interview with Administrative (Admin.) Staff #2 was conducted. Admin. Staff #2 indicated client #37 was not served the correct texture of diet while on an outing on 2/24/13 and choked as the result. Admin. Staff #2 indicated a mechanical soft diet is a diet that was mechanically altered. Admin. Staff #2 indicated the meat should not have been quartered; the meat should have been cut up small or ground up. Admin. Staff #2 indicated the facility staff failed to ensure client #37 had a mechanical soft diet.</p> <p>2. Observations were conducted on the 2nd floor of the facility on 7/9/13 from 6:10 AM through 8:30 AM. At 7:20 AM client #9 was escorted to the dining room for her morning meal. One item of pureed food was placed on client #9's plate. SW (Social Worker) #1 began feeding client #9 the pureed food. When asked what she was feeding client #9, the SW #1 stated, "Eggs and banana bread." When asked where are the eggs, SW #1 indicated the eggs and banana bread were pureed together in the kitchen when prepared and sent to the floor from the kitchen already mixed together.</p> <p>Interview with CNA (Certified Nursing</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  07/22/2013	
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>Aide) #5 on 7/9/13 at 7:55 AM indicated she was told by the dietary staff that brought up client #9's food, the dietician had "mixed the pureed food together today for some reason, but I'm not sure why."</p> <p>3. A mealtime observation was conducted on the first level on 7/8/13 from 5:45 P.M. until 6:25 P.M.. At 6:00 P.M. client #4 was observed eating his dinner which consisted of a beige pureed textured substance, a white liquidy substance, a red mechanical soft texture substance and chocolate cake. Client #4 did not receive a regular diet. At 6:05 P.M., client #1 was observed eating his dinner which consisted of pureed turkey meat, mashed potatoes, pureed beets and chocolate pudding. Client #1 did not receive double portions during his dinner meal.</p> <p>An interview with Program Director (PD) #1 was conducted on 7/8/13 at 6:15 P.M.. When asked what client #4 was having for dinner she stated "A turkey wrap, potato salad, beets and chocolate cake. This potato salad looks more like au gratin potatoes." When asked what consistency the meal was, she stated "It looks like it's pureed." When asked what diet client #4 was on, PD #1 stated "He's on a regular diet."</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  07/22/2013
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>A review of client #1's record was conducted on 7/11/13 at 9:30 A.M.. Review of client #1's most current dietary assessment dated 2/11/3 indicated he was on a pureed diet with double portions.</p> <p>A review of client #4's record was conducted on 7/11/13 at 11:50 A.M.. Review of client #4's most current dietary assessment dated 12/9/12 indicated he was on a regular diet.</p> <p>An interview with Registered Nurse (RN) #7 was conducted on 7/12/13 at 1:30 P.M.. When asked if clients should be provided their prescribed diet orders, the RN stated "Yes."</p> <p>3.1-20(a)</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  07/22/2013	
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			
W009999	<p>STATE FINDINGS</p> <p>1. 3.1-20 DIETARY SERVICES Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1; IC 25-14.5</p> <p>Sec. 20. (a) The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special daily needs of each resident.</p> <p>(b) The facility must employ a qualified dietician either full time, part time, or on a consultant basis.</p> <p>(c) If a qualified dietitian is not employed full time, the facility must designate a qualified person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.</p> <p>(d) A qualified dietitian is one who is certified under IC 25-14.5. However, a person employed by a health facility as of July 1, 1984, must:</p> <p>(1) have a bachelor's degree with major studies in food management.</p> <p>(2) have one (1) year of supervisory experience in the dietetic service of a health care institution; and</p> <p>(3) participate annually in continuing dietetic education.</p> <p>(e) The food service director must be one</p>	W009999	<p>9999</p> <p>I Recruitment is in process for a full time Dietary Manager. The Assistant Dietary Manager (ADD) is serving as the temporary Dietary Manager at this time. She is assisted with oversight by the Registered Dietitian (RD). ADD and Dietary staff have been re-educated as to the proper temperature to serve food and drinks. The cart with food debris on the shelves has been cleaned. Dietary staff have been re-educated that foods must be discarded when they reach their expiration date. This check for dates is part of the P-2 Dietary Aide task list. Dietary staff have been re-educated that the dishwasher wash temperature must be 150 and the rinse temperature 180 and to document actual temperature on the log. When Dishwasher does not maintain 150 for wash and 180 for rinse, ADD will put in a work order and in inform Maintenance Director. Three compartment sink has been repaired. Dietary staff re-educated that clean dishes must be dry and that equipment must be in good repair.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III ED has consulted with the</p>	08/21/2013			

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  07/22/2013	
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>(1) of the following:</p> <p>(1) A qualified dietitian.</p> <p>(2) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year experience in some aspect of institutional food service management.</p> <p>(3) A graduate of dietetic technician program approved by the American Dietetic Association.</p> <p>(4) A graduate of an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year experience in some aspect of food service management.</p> <p>(5) An individual with training and experience in food service supervision and management in a military service equivalent in content to the program in subdivisions (2), (3), and (4).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed for 15 of 15 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) and for 133 additional clients (clients #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30,</p>		<p>Golden Living recruiter for further candidates. ADD continues to fill in for the DSM with oversight by the RD. Food and drink temperatures are taken prior to taking the food and drink to each floor for serving to assure it is correct. Dietary staff have been re-educated on the cleaning schedule which includes the cart with food debris on the shelves. ADD will follow up to assure P-2 task list has been completed which includes checking for outdated foods. ADD has been trained to put work orders in building engine system so that Maintenance has the information that something needs repaired. Ice scoop and container have been replaced. Dietary staff re-educated that dishes must be dry. ADD to assure dishes are dry by spot checking dishes prior to meal delivery.</p> <p>IV Interviewing continues and a qualified candidate will be hired for the DSM position. Until then the ADD will fill in for the DSM with oversight from the RD. ED is responsible to hire the DSM. When Dishwasher does not maintain 150 for wash and 180 for rinse, ADD/designee will put in a work order and in inform Maintenance Director for immediate action. When repair has been requested and no action taken for three days, ADD will inform ED for further action and follow up on Maintenance.</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  07/22/2013	
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>#31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) to ensure the facility had a qualified director of food service.</p> <p>Findings include:</p> <p>On 7/10/13 from 7:45am until 10:15am, the dietary department was observed and no dietary manager was available. At 7:45am, the Assistant Director of Dietary (ADD) indicated the facility did not have a current dietary manager. The ADD indicated she had not completed an approved course for dietary and was not the director of dietary.</p> <p>On 7/11/13 at 12:35pm, an interview was conducted with the Director of Clinical</p>		<p>ADD educated that when equipment in need of replacement it must be replaced. Dining monitors check dishes delivered to meals to assure they are dry. If not, Dietary replaces them with clean and dry dishes. Completed by 8-21-13.</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  07/22/2013	
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>Education (DCE). The DCE stated the Registered Dietitian was a "consultant only." The DCE indicated the Registered Dietitian was present in the facility seven (7) hours every two weeks.</p> <p>On 7/11/13 at 4pm, an interview and record review was conducted with the Registered Dietitian (RD). The RD indicated the facility did not have a qualified dietary manager employed at this time. The RD indicated she was a part time consultant and visited the facility every week for eight (8) hours. The RD provided an undated schedule which indicated she visited the facility weekly on Tuesdays from 8:30am until 4:30pm.</p> <p>On 7/11/13 at 4pm, an interview and record review was conducted with the DCE. The DCE provided the facility 2013 "Labor" profile which indicated the facility budgeted for 1 full time dietary manager and 1 full time assistant dietary manager. The DCE indicated the facility was currently recruiting a full time qualified dietary manager.</p> <p>On 7/15/13 at 10:42am, an interview with the facility's Administrator was conducted. The Administrator indicated the current RD was a consultant. The Administrator indicated the facility did</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  07/22/2013	
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>not have a current full time qualified dietary manager. The Administrator indicated the facility had been without a dietary manager since 6/20/13. The Administrator indicated the facility was advertising, recruiting, and interviewing candidates currently for the dietary manager position.</p> <p>2. 3.1-21 FOOD Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1</p> <p>Sec. 21. (a) Each resident receives and the facility provides the following: (1) Food prepared by methods that conserve nutritive value, flavor, and appearance. (2) Food that is palatable, attractive, and at the proper temperature. (i) The facility must do the following: (3) Store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review, and interview the facility failed for 15 of 15 sampled clients (clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) and for 133 additional clients (clients #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30,</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  07/22/2013	
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>#31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, and #148) to provide food at the proper temperature, ensure sanitary conditions, and to remove out dated food from use.</p> <p>Findings include:</p> <p>During a kitchen observation on 07/10/2013 from 7:45am until 10:15am with the Assistant Director of Dietary (ADD), the following was observed:</p> <p>-At 7:45am, the ADD and Dietary Staff (DS) #48 loaded the Coffee bin on a cart, the Orange Juice bin on a cart, and the third cart with pans of food for the third floor. At 8:00am, the food and drinks arrived on the third floor for clients</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  07/22/2013
--	---	--	---

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>waiting for breakfast. At 8:00am, the ADD and DS #48 indicated the pureed food was not at the correct temperature and the ADD removed the pureed food pans, loaded them back onto a cart, and took the cart back to the basement to dietary for heating. Clients for the first dining room seating on the third floor filled their glasses with Orange Juice and Coffee.</p> <p>-On 7/10/13 at 8:15am, the third floor Orange Juice cooler bin (a thermal bin which held liquid orange juice dispersed by a spicket) was 56.1 degrees Fahrenheit and had a sour tart flavor. At 10:15am, the ADD indicated the Orange Juice should have been 41 degrees Fahrenheit or below.</p> <p>-On 7/10/13 at 8:15am, the third floor Coffee bin (a thermal bin which held liquid coffee dispersed by a spicket) was 126.4 degrees Fahrenheit. At 10:15am, the ADD indicated the Coffee from the bin should have been 140 degrees Fahrenheit or higher.</p> <p>-On 7/10/13 at 9:10am, DS #48 served a test tray on a plastic plate of Oatmeal 120 degrees Fahrenheit, pureed pancakes 90 degrees Fahrenheit, and pureed meat (sausage) 90 degrees Fahrenheit. DS #48 indicated the temperatures should have</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  07/22/2013
--	---	--	---

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>been 140 degrees Fahrenheit or above for hot food. At 9:10am, DS #48 indicated the regular pancakes were 120 degrees Fahrenheit on the steam table, the pureed meat was 100 degrees on the steam table, and the pureed pancakes were 120 degrees Fahrenheit on the steam table.</p> <p>-On 7/10/13 at 9:15am, inside the kitchen a food cart was observed being prepared for the lunch meal. The cart doors of the cart were open, condiments on a tray were inside the food cart, and sixteen of sixteen (16/16) metal cart shelves were dusty and had food debris on them.</p> <p>-On 7/10/13 at 9:20am, inside the kitchen reach in freezer were three (3) forty-eight ounces (48oz.) loaves of Cream Cheese which expired on 10/5/2012. The ADD indicated the Cream Cheese was expired and should have been removed from use.</p> <p>-On 7/10/13 at 10:00am, the spice shelves had an opened sixteen ounce (16oz.) bottle of Cinnamon Glaze which indicated "best by 7/2012," a 16oz. an opened bottle of Lemon Glaze which indicated "best by 4/2012," and the ADD picked up both items after they were identified then threw them both away into the trash.</p> <p>-On 7/10/13 at 10:00am, the dish washer</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  07/22/2013	
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>temperature was 142 degrees Fahrenheit for the wash cycle and 170 degrees Fahrenheit for the rinse cycle. The Dish Machine temperature log was requested for review and the ADD indicated she would provide it later. The ADD indicated the wash cycle should be 150 degrees Fahrenheit for the wash cycle and 180 degrees Fahrenheit for the rinse cycle.</p> <p>-On 7/10/13 at 9:30am, the three compartment sink had food debris in the drain and it was dried to each of the three bays in the sink. The ADD indicated the three compartment sink was not operational and could not be used. The ADD indicated the sink had been broken over one year.</p> <p>-On 7/10/13 at 9:30am, a liquid was observed between dishes stacked and stored as clean. The Ice Machine scoop was cracked, and stored in a plastic broken sleeve without a covering on the side of the ice machine in the food preparation area. On a cart stored as clean were four of four (4/4) pitchers stored upside down which had water draining from each of the pitchers onto the cart. The cart had food debris on the cart and under the upside down pitchers. There were two of five (2/5) Juice coolers that were stained and had a dark build up of a brown substance.</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  07/22/2013	
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>An interview on 07/11/2013 at 3:00pm, the ADD indicated the wash cycle temperature was 150 degrees Fahrenheit and the rinse cycle was 180 degrees Fahrenheit. The ADD indicated the temperatures were checked and recorded after each meal, then added numbers to the "Dish Machine Temperature Log " before making a copy of the log. The Dietary Manager indicated the dishes are checked for cleanliness before they are put away.</p> <p>An undated policy, titled, "Damaged China and Glassware Surveillance" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...Damaged items are immediately taken out of service...."</p> <p>A 2011 policy, titled, "Dish Machine Use and Care" was provided by the ADD on 7/11/13 at 3:00pm. The policy indicated, "...High Temperature machine, Wash - temperature must be maintained at a minimum of 150 F (degrees Fahrenheit) per state regulations during the wash cycle time. Rinse - Temperature must be maintained at a minimum of 180 (degrees) F per gauge...."</p> <p>3.1-20(e)(2) 3.1-21(i)(3)</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  07/22/2013
--	---	--	---

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