

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 post-certification revisit survey to the pre-determined full recertification and state licensure survey completed on 7/22/13.</p> <p>Dates of Survey: 9/3, 9/4 and 9/5/13</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 9/26/13 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 3 additional clients (#63, #100, and #134), the facility failed to implement its written policy and procedures to prevent neglect of clients to ensure safeguards were implemented to prevent clients #63, #100, and #134 from further injury due to falls, to ensure clients were monitored/supervised, to</p>	W000149	<p>W 149In addition to the IDT team review quarterly and annually which is assured by the Program Director, the Quality Assurance team is reviewing each fall IDT with follow up as needed. A safety audit has been implemented beginning 10-14-13 completed by the QMRP three times per week which includes fall risk implementation and providing education as needed. W149I Clients 63, 100 and 134 have a fall risk plan that has been developed and or updated and trained with staff. II All residents with history of falls may be at risk from this deficient practice. III Clients with fall risk have a fall risk plan developed and or updated and trained with their staff. IV Program Directors review client plans to assure needs are met and training is implemented. To be completed by October 8, 2013.</p>	10/08/2013	

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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 effective corrective action after clients continued to fall, and to ensure client #100's unknown fall with injuries was thoroughly investigated.</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 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #100:</p> <p>-A 7/11/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 7/10/13 at 12:15pm indicated client #100 was found on the toilet in his room with a laceration to his left eyebrow during a "routine bed check after lunch." The report indicated client #100 was "in bed" after his tube feeding. The report indicated client #100's head was bleeding, "staff reported [client #100] stated he fell." The report indicated client #100's nursing notes indicated a superficial laceration one inch in length to left eyebrow and a scratch to the back of his left hand. The report indicated client #100 requires stand by assistance of staff to transfer/walk, and required a wheelchair for long distances.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 report indicated client #100 had a history of falls. The report indicated client #100 fell on 6/19/13 from the toilet with an abrasion to his right knee, on 6/8/13 from his bed, and on 4/7/13 during a seizure. The report indicated the IDT (Interdisciplinary Team) recommended a bed alarm to prevent further injuries.</p> <p>-A 7/10/13 Behavior Incident Report (BIR) indicated an incident on 7/10/13 at 12:15pm, in which a nursing staff indicated client #100 had been in bed sleeping, the bathroom door was open with the light off, and the staff turned on the light to discover client #100 on the toilet injured.</p> <p>The facility's BIR and/or BDDS report did not indicate the facility conducted an investigation as no witness statements from clients, staff and/or the nurse, who completed client #100's tube feeding, were completed. The facility's BDDS report did not indicate if the environment was checked for evidence of a fall, if client #100 had his helmet available for use, if client #100 was an accurate reporter of events, if client #100's bed checks were completed, and/or if client #100 had other interventions in place to prevent the injury.</p> <p>-A 7/28/13 BDDS report for an incident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 7/28/13 at 8:30am, indicated client #100's "alarm sounding. [Staff] went to the room and found him on the floor." The report indicated client #100 had leaned over from his wheel chair to pick up baseball cards on the program room floor and he fell out of his wheel chair. Client #100 had "a red mark on his back that did not immediately fade." The report indicated client #100's "pelvic stabilizer" was not closed and he did not have his lap tray on his wheel chair. Client #100 remained on 15 minute checks.</p> <p>Client #100's record was reviewed on 9/5/13 at 6:50am. Client #100's 8/6/13 and 7/21/13 "Physician's Orders" indicated:</p> <ul style="list-style-type: none"> -A physician's order on 7/11/2013 for a bed alarm. -A physician's order on 7/20/2010 for a wheelchair with a pelvic stabilizer due to unsteady Gait (walking). -A physician's order on 12/13/12 for a lap tray when up in his wheelchair. <p>-Client #100's record indicated he was on 15 minute bed checks while in bed, the use of a pelvic stabilizer, and a helmet because of seizures.</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #5 both indicated client #100 had indicated that he fell and no further investigation was needed. Administrative Staff #2 indicated client #100's injuries were not witnessed. Administrative Staff #2 stated an unwitnessed fall "was usually investigated." Administrative Staff #2 stated client #100's injuries "could be" suspicious. Administrative Staff #2 indicated the facility staff neglected to ensure client #100's pelvic stabilizer and staff supervision was in place to prevent client #100 from falling. Administrative Staff #2 indicated the investigative component did not determine corrective action for client #100's falls.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated client #100 was at risk for further injuries from falls and had a history of falls. PD #3 did not respond when asked whether the corrective action for client #100 was effective after he continued to fall. PD #3 stated if client #100's seat belt, lap tray, or bed alarm was not used it would be a "failure" of the facility staff. PD #3 stated if the investigation did not include whether or not client #100's equipment was in place at the time of each incident and no witness statements then the investigation would not be a "thorough" investigation.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #63:</p> <p>-A 7/25/13 BDDS report for an incident on 7/25/13 at 2:18pm, indicated client #63 was in the hallway, leaned forward while seated in his wheel chair, and the wheel chair tipped forward with pelvic stabilizer intact. Client #63 hit his head when he fell. The report indicated client #63 had fallen on 7/14/13 and had hit the same area of his head. The report indicated client #63 was sent to the Emergency Room (ER) for a "Scalp Abrasion." The report indicated front anti tippers to prevent the wheel chair from tipping over were added. The report indicated client #63 "will be encouraged to go to classroom for programs with peers and staff." The report did not indicate if client #63's wheel chair alarm was in place and operational.</p> <p>-Client #63's 7/25/13 investigation record indicated an 8/3/2012 "Focus" Goal: "At risk for falls related to History of Falls secondary to impaired safety awareness,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>seizure disorder...bed in low position, mat on floor, bed and chair alarms (dated 6/2012)...Gait belt with transfers, provide equipment as ordered: pelvic stabilizer, alarms to bed and (wheel) chair...front and back anti tippers on wheelchair."</p> <p>-Client #63's 7/25/13 investigation record indicated an 7/25/13 "Hospital ER Report" which indicated "Scalp Abrasion...[Signed by the Administrative Staff #5]."</p> <p>-Client #63's 7/26/13 IDT (interdisciplinary team) indicated client #63 had fallen from his wheel chair on 7/25/13. The "team (IDT) implemented the following measures to keep him safe: 1. 15 minutes/checks to monitor and ensure that [client #63] is safe until a comprehensive plan is put in place. 2. [Client #63's] wheel chair has been fitted with front anti tippers to make the new wheel chair more safe. will continue to use a pelvic stabilizer and wheel chair alarm at all times he is on his wheel chair (sic). 3. [Client #63] will be encouraged to seek help to pick up his toys or programming materials from the floor when he drops them...His toys will be placed within his reach and any toys on the floor will be picked up and placed on the table for easy access...15 minute checks were discontinued."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 9/5/13 from 6:15am until 7:50am, client #63 was in bed asleep. From 7:50am until 8:25am, client #63 was seated in his wheelchair, his pelvic stabilizer was around his waist and strapped to his wheel chair, and the space between the strap and client #63 was four inches. At 8:05am, client #63 was seated in his wheel chair in the classroom with three other clients and no facility staff were present or within eye sight of client #63. At 8:06am, client #63 dropped a plastic block on the floor, leaned forward in his wheelchair, the front anti tippers of his wheelchair made a clicking noise against the floor, and his wheel chair alarm string dislodged from the control box for the alarm on the back of the wheel chair. At 8:09am, Staff #7 entered the program room from the hallway, reattached client #63's string to the alarm box, and left the room. No staff was within eye sight of client #63. The staff did not pick up the items client #63 dropped to the floor and did not ask client #63 what he needed. From 8:06am until 8:15am, client #63 continued to attempt to pick up the items he dropped on the floor. At 8:15am, client #63 leaned far enough forward again to cause the string on the wheel chair alarm to dislodge from the box and to sound. Staff #7 immediately came into the program room,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reconnected client #63's string to the control box for the alarm, and took client #63 out to the hallway in his wheel chair. At 8:20am, client #63 was observed in the hallway. At 8:20am, staff #7 stated client #63 was at risk for falls and was to be supervised within eye sight of the facility staff "at all times" when client #63 was awake. At 8:20am, staff #8 stated client #63 was to be "supervised within eye sight at all times" because client #63 was at risk to fall. Staff #8 stated he applied client #63's pelvic stabilizer today and it was "loose fitting" on client #63.</p> <p>Client #63's record was reviewed on 9/5/13 at 8:25am. Client #63's 7/2013 Physician Orders indicated "Bed alarm to w/c (wheel chair) and bed while seated and while in bed due transferring (sic) and getting out of bed unassisted for client safety due to unsteady gait and history of falls...May use W/C due to unsteady gait and falls, may utilize gait belt during transfers, may use lap stabilizer while up in w/c for safety."</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #63 was at risk to fall and had a history of falling. Administrative Staff #2 indicated the investigative component did not determine the effectiveness 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>corrective action to address client #63's falling.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated facility staff should be inside the classroom with client #63 and stated "within eyesight" supervision. PD #3 stated if client #63's seat belt, or alarms were not used it would be a "failure" by the facility staff. PD #3 stated if the investigation did not include whether or not client #63's equipment was in place at the time of each incident and no witness statements, then the investigation would not be a "thorough" investigation.</p> <p>3. On 9/5/13 at 7:50am, client #134 was observed sitting in the hallway in a small wheel chair with two facility staff, one staff on each side of client #134. At 7:50am, client #134 indicated her wheel chair was too small for her and indicated she (client #134) was larger than the wheel chair would hold. At 7:50am, both of client #134's one on one staff indicated client #134's wheel chair was too small and client #134's body hung over the arm rests of the wheel chair. At 7:50am, client #134 extended her right arm and exposed a scratch from the upper right shoulder to her elbow which was red in color. Client #134 indicated she had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>fallen on 9/4/13.</p> <p>The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #134:</p> <p>-Client #134's 8/22/13 "Falls Assessment Analysis Form" indicated client #134 had had fallen on 8/22/13 and "Previous falls: 7/23/13 at 1pm and at 6:35pm, 7/22/13, 7/16/13, 7/11/13, 6/22/13, 5/24/13, 5/18/13, and 5/15/13."</p> <p>Client #134's Falls record indicated during each fall, client #134 had one on one staff supervision in place:</p> <p>-On 8/22/13 at 2:45pm, client #134 had one on one staff supervision, had refused to use her walker and wheel chair, and fell. The report indicated no injury.</p> <p>-A 7/24/13 BDDS report for a fall on 7/24/13 at 9:55am, indicated client #134 "was walking without walker (sic) in the corridor on first floor, she fell forward, struck her lip. The lip was bleeding and there was blood in her mouth." The record indicated "9-1-1 was notified,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 was sent to the hospital for evaluation and treatment." The report indicated "skin glue was applied to the laceration on her lip" and the hospital diagnosis was "fall, lip laceration, also had bruising to the 4th and 5th fingers on her left hand." The report indicated client #134 "has a pattern of falls without injury associated with a refusal to use her walker or to accept assistance...1:1 (one on one) staffing continues (for supervision) to be in place."</p> <p>-On 7/23/13 at 6:35pm, client #134 was using the toilet and stood up to clean herself and lost balance and fell. No injury was noted.</p> <p>-On 7/23/13 at 1pm, client #134 was "angry," had one on one staff supervision, refused wheel chair and walker. Client fell and no injury was noted.</p> <p>-On 7/22/13 at 9:20am, client #134 was returning from dining room, forgot to lock her walker, and fell on her buttocks. No injury was noted.</p> <p>-On 7/16/13 no time documented, client #134 fell due to refusal to use her walker or wheel chair.</p> <p>-On 7/11/13 at 10am, client #134 was talking, got upset, walked away from 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 her walker, and fell to the floor. No injury was noted.</p> <p>On 9/5/13 at 10am, client #134's 9/4/13 BDDS report for an incident on 9/4/13 at 12:40pm, indicated client #134 had one on one staff supervision, had become aggressive, was not safe with herself or others, and was sent to the hospital for evaluation.</p> <p>-Client #134's 9/4/13 at 9:15am, investigation note indicated client #134 had "sustained a superficial abrasion to her RUE (right upper extremity) from the shoulder to the elbow" and the client "just fell." After her behavior continued the facility sent her to the hospital for evaluation.</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #134 was at risk to fall and had a history of falling. Administrative staff #2 indicated even with one on one staff and interventions to use a walker and/or wheel chair, client #134 continued to fall. Administrative Staff #2 indicated the investigative component does not determine if the corrective action was effective to address client #134's falls.</p> <p>On 9/5/13 at 10am, an interview 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 (PD) #3 was conducted. PD #3 indicated client #134 continued to fall with one on one staff supervision. PD #3 indicated if client #134 did not use her walker or wheel chair staff would need to teach and encourage their use. When asked if client #134's interventions were effective to prevent her from falling, PD #3 indicated client #134 continued to fall.</p> <p>The facility's policy and procedures were reviewed on 9/3/13 at 1:10 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</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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):</p> <p>"Abuse the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Neglect means failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness...."</p> <p>This deficiency was cited on 7/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W000154	W 154I Client 100's IDT has met and determined that he is acting as his usual self and verbalizes that he is happy to be back home at North Willow.He has had no falls since 7-28-13 and no unknown injuries noted. The IDT has assessed and determined whether client 100 would be a reliable witness and under what circumstances. This information is now noted. II All residents with history of falls may be at risk from this deficient practice. III The IDT has assessed and determined whether each client would be a reliable witness and under what circumstances. This information is now noted and a system for reassessment has been determined and trained with QMRPs. Unwitnessed falls which are not reported by a client who is determined to be a reliable witness will be treated as unknown when injury is involved. If a fall is self reported without injury, it will still be investigated as a fall which is the current practice. Client Advocates have been trained on this updated practice. IV The Human Rights Coordinator assures the quality of the investigations by the Client Advocates. Program Directors assure that assessment is completed as to client being a	10/08/2013	

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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on interview and record review for 1 of 15 injuries of unknown source reviewed (for client #100), the facility failed to conduct a thorough investigation in regard to client #100's unknown head injury.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #100:</p> <p>-A 7/11/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 7/10/13 at 12:15pm indicated client #100 was found on the toilet in his room with a laceration to his left eyebrow during a "routine bed check after lunch." The report indicated client #100 was "in bed" after his tube feeding. The report indicated client #100's head was bleeding, "staff reported [client #100] stated he fell." The report indicated client #100's nursing notes indicated a superficial laceration one inch</p>		reliable witness and documentation of same. To be completed by October 8, 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 length to left eyebrow and a scratch to the back of his left hand. The report indicated client #100 requires stand by assistance of staff to transfer/walk, and required a wheelchair for long distances. The report indicated client #100 had a history of falls. The report indicated client #100 fell on 6/19/13 from the toilet with an abrasion to his right knee, on 6/8/13 from his bed, and on 4/7/13 during a seizure. The report indicated the IDT (Interdisciplinary Team) recommended a bed alarm to prevent further injuries.</p> <p>-A 7/10/13 Behavior Incident Report (BIR) indicated an incident on 7/10/13 at 12:15pm, in which a nursing staff indicated client #100 had been in bed sleeping, the bathroom door was open with the light off, and the staff turned on the light to discover client #100 on the toilet injured.</p> <p>The facility's BIR and/or BDDS report did not indicate the facility conducted an investigation as no witness statements from clients, staff and/or the nurse, who completed client #100's tube feeding, were completed. The facility's BDDS report did not indicate if the environment was checked for evidence of a fall, if client #100 had his helmet available for use, if client #100 was an accurate reporter of events, if client #100'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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>checks were completed, and/or if client #100 had other interventions in place to prevent the injury.</p> <p>Client #100's record was reviewed on 9/5/13 at 6:50am. Client #100's 8/6/13 and 7/21/13 "Physician's Orders" indicated:</p> <ul style="list-style-type: none"> -A physician's order on 7/11/2013 for a bed alarm. -A physician's order on 7/20/2010 for a wheelchair with a pelvic stabilizer due to unsteady Gait (walking). -A physician's order on 12/13/12 for a lap tray when up in his wheelchair. <p>-Client #100's record indicated he was on 15 minute bed checks while in bed.</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #100 had indicated that he fell and no further investigation was needed. Administrative Staff #2 indicated client #100's injuries were not witnessed. Administrative Staff #2 stated an unwitnessed fall "was usually investigated." Administrative Staff #2 stated client #100's injuries "could be" suspicious.</p> <p>This deficiency was cited on 7/22/13. The facility failed to implement 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	systemic plan of correction to prevent recurrence. 3.1-28(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview for 1 of 15 sample clients (#2) and 3 additional clients (#63, #100, and #134), the facility failed to take effective corrective action to ensure safeguards were implemented to prevent clients #63, #100, and #134 from further injury due to falls/ensure clients were monitored/supervised, and to secure client #2's wheel chair padding to prevent injury.</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 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #100:</p> <p>-A 7/11/13 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 7/10/13 at 12:15pm indicated client #100 was found on the toilet in his room with a laceration to his left eyebrow during a "routine bed check after lunch." The report indicated</p>	W000157	<p>W157I Client 2's wheel chair is padded as prescribed. Client 100 has a bed alarm and his fall risk plan has been updated and trained. Client 134's fall risk plan has been updated and retrained and she has a wheel chair that fits her body. Client 63's fall risk plan has been updated and retrained. II Any resident needing corrective actions completed may be at risk for this deficient practice. III Clients with fall risk have a fall risk plan developed and or updated and trained with their staff. Client Advocate assigned to investigation communicates with Program Directors and/or QMRP staff for resident to assure that what is communicated in their report is consistent with the needs of the resident and the IDT recommendations that are made. IV Human Rights Coordinator assures that Client Advocates communicate with Program Director/QMRP staff on behalf of client needs and Program Directors assure that recommended IDT follow up is completed and shared with the Client Advocate office. To be completed by October 8, 2013.</p>	10/08/2013			

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #100 was "in bed" after his tube feeding. The report indicated client #100's head was bleeding, "staff reported [client #100] stated he fell." The report indicated client #100's nursing notes indicated a superficial laceration one inch in length to left eyebrow and a scratch to the back of his left hand. The report indicated client #100 requires stand by assistance of staff to transfer/walk, and required a wheelchair for long distances. The report indicated client #100 had a history of falls. The report indicated client #100 fell on 6/19/13 from the toilet with an abrasion to his right knee, on 6/8/13 from his bed, and on 4/7/13 during a seizure. The report indicated the IDT (Interdisciplinary Team) recommended a bed alarm to prevent further injuries.</p> <p>-A 7/10/13 Behavior Incident Report (BIR) indicated an incident on 7/10/13 at 12:15pm, in which a nursing staff indicated client #100 had been in bed sleeping, the bathroom door was open with the light off, and the staff turned on the light to discover client #100 on the toilet injured.</p> <p>The facility's BIR and/or BDDS report did not indicate if the environment was checked for evidence of a fall, if client #100 had his helmet available for use, if client #100 was an accurate reporter 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>events, if client #100's bed checks were completed, or if client #100 had other interventions in place to prevent the injury.</p> <p>-A 7/28/13 BDDS report for an incident on 7/28/13 at 8:30am, indicated client #100's "alarm sounding. [Staff] went to the room and found him on the floor." The report indicated client #100 had leaned over from his wheel chair to pick up baseball cards on the program room floor and he fell out of his wheel chair. Client #100 had "a red mark on his back that did not immediately fade." The report indicated client #100's "pelvic stabilizer" was not closed and he did not have his lap tray on his wheel chair. Client #100 remained on 15 minute checks.</p> <p>Client #100's record was reviewed on 9/5/13 at 6:50am. Client #100's 8/6/13 and 7/21/13 "Physician's Orders" indicated:</p> <p>-A physician's order on 7/11/2013 for a bed alarm.</p> <p>-A physician's order on 7/20/2010 for a wheelchair with a pelvic stabilizer due to unsteady Gait (walking).</p> <p>-A physician's order on 3/29/13 for a helmet in use.</p> <p>-A physician's order on 12/13/12 for a lap tray when up in his wheelchair.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #100's record indicated he was on 15 minute bed checks while in bed, the use of a pelvic stabilizer, lap tray, and a helmet because of seizures.</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #100 had indicated that he fell and no further investigation was needed. Administrative Staff #2 indicated client #100's injuries were not witnessed. Administrative Staff #2 stated an unwitnessed fall "was usually investigated." Administrative Staff #2 stated client #100's injuries "could be" suspicious. Administrative Staff #2 indicated the facility staff failed to ensure client #100's pelvic stabilizer and staff supervision was in place to prevent client #100 from falling. Administrative Staff #2 indicated the investigative component did not determine the effectiveness of the corrective action for client #100's falls.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated client #100 was at risk for further injuries from falls and had a history of falls. PD #3 did not respond when asked whether the corrective action for client #100 was effective after he continued to fall. PD #3 indicated 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #100's seat belt, lap tray, or bed alarm was not used it would be a failure by the facility staff.</p> <p>2. The facility's reportable incident reports, Fall Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #63:</p> <p>-A 7/25/13 BDDS report for an incident on 7/25/13 at 2:18pm, indicated client #63 was in the hallway, leaned forward while seated in his wheel chair, and the wheel chair tipped forward with pelvic stabilizer intact. Client #63 hit his head when he fell. The report indicated client #63 had fallen on 7/14/13 and had hit the same area of his head. The report indicated client #63 was sent to the Emergency Room (ER) for a "Scalp Abrasion." The report indicated front anti tippers to prevent the wheel chair from tipping over were added. The report indicated client #63 "will be encouraged to go to classroom for programs with peers and staff." The report did not indicate if client #63's wheel chair alarm was in place and operational.</p> <p>-Client #63's 7/25/13 investigation record</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 an 8/3/2012 "Focus" Goal: "At risk for falls related to History of Falls secondary to impaired safety awareness, seizure disorder...bed in low position, mat on floor, bed and chair alarms (dated 6/2012)...Gait belt with transfers, provide equipment as ordered: pelvic stabilizer, alarms to bed and (wheel) chair...front and back anti tippers on wheelchair."</p> <p>-Client #63's 7/25/13 investigation record indicated an 7/25/13 "Hospital ER Report" which indicated "Scalp Abrasion...[Signed by the Administrative Staff #5]."</p> <p>-Client #63's 7/26/13 IDT(interdisciplinary team) indicated client #63 had fallen from his wheel chair on 7/25/13. The "team (IDT) implemented the following measures to keep him safe: 1. 15 minutes/checks to monitor and ensure that [client #63] is safe until a comprehensive plan is put in place. 2. [Client #63's] wheel chair has been fitted with front anti tippers to make the new wheel chair more safe. will continue to use a pelvic stabilizer and wheel chair alarm at all times he is on his wheel chair (sic). 3. [Client #63] will be encouraged to seek help to pick up his toys or programming materials from the floor when he drops them...His toys will be placed within his reach and any toys 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 floor will be picked up and placed on the table for easy access...15 minute checks were discontinued."</p> <p>On 9/5/13 from 6:15am until 7:50am, client #63 was in bed asleep. From 7:50am until 8:25am, client #63 was seated in his wheelchair, his pelvic stabilizer was around his waist and strapped to his wheel chair, and the space between the strap and client #63 was four inches. At 8:05am, client #63 was seated in his wheel chair in the classroom with three other clients and no facility staff were present or within eye sight of client #63. At 8:06am, client #63 dropped a plastic block on the floor, leaned forward in his wheelchair, the front anti tippers of his wheelchair made a clicking noise against the floor, and his wheel chair alarm string dislodged from the control box for the alarm on the back of the wheel chair. At 8:09am, Staff #7 entered the program room from the hallway, reattached client #63's string to the alarm box, and left the room. No staff was within eye sight of client #63. The staff did not pick up the items client #63 dropped to the floor and did not ask client #63 what he needed. From 8:06am until 8:15am, client #63 continued to attempt to pick up the items he dropped on the floor. At 8:15am, client #63 leaned far enough forward again to cause the string</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 the wheel chair alarm to dislodge from the box and to sound. Staff #7 immediately came into the program room, reconnected client #63's string to the control box for the alarm, and took client #63 out to the hallway in his wheel chair. At 8:20am, client #63 was observed in the hallway. At 8:20am, staff #7 stated client #63 was at risk for falls and was to be supervised within eye sight of the facility staff "at all times" when client #63 was awake. At 8:20am, staff #8 stated client #63 was to be "supervised within eye sight at all times" because client #63 was at risk to fall. Staff #8 stated he applied client #63's pelvic stabilizer today and it was "loose fitting" on client #63.</p> <p>Client #63's record was reviewed on 9/5/13 at 8:25am. Client #63's 7/2013 Physician Orders indicated "Bed alarm to w/c (wheel chair) and bed while seated and while in bed due transferring (sic) and getting out of bed unassisted for client safety due to unsteady gait and history of falls...May use W/C due to unsteady gait and falls, may utilize gait belt during transfers, may use lap stabilizer while up in w/c for safety."</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #63 was at risk to fall and 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>history of falling. Administrative Staff #2 indicated the investigative component did not determine the effectiveness of the corrective action to address client #63's falling.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated facility staff should be inside the classroom with client #63 and stated "within eyesight" supervision. PD #3 stated if client #63's seat belt, or alarms were not used it would be a "failure" by the facility staff.</p> <p>3. On 9/5/13 at 7:50am, client #134 was observed sitting in the hallway in a small wheel chair with two facility staff, one staff on each side of client #134. At 7:50am, client #134 indicated her wheel chair was too small for her and indicated she (client #134) was larger than the wheel chair would hold. At 7:50am, both of client #134's one on one staff indicated client #134's wheel chair was too small and client #134's body hung over the arm rests of the wheel chair. At 7:50am, client #134 extended her right arm and exposed a scratch from the upper right shoulder to her elbow which was red in color. Client #134 indicated she had fallen on 9/4/13.</p> <p>The facility's reportable incident reports,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 Reports, Hospital Reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 9/3/13 at 1:30pm and on 9/4/13 at 7:45am. The facility's reportable incident reports, Fall Reports, and/or investigations indicated the following for client #134:</p> <p>-Client #134's 8/22/13 "Falls Assessment Analysis Form" indicated client #134 had had fallen on 8/22/13 and "Previous falls: 7/23/13 at 1pm and at 6:35pm, 7/22/13, 7/16/13, 7/11/13, 6/22/13, 5/24/13, 5/18/13, and 5/15/13."</p> <p>Client #134's Falls record indicated during each fall, client #134 had one on one staff supervision in place:</p> <p>-On 8/22/13 at 2:45pm, client #134 had one on one staff supervision, had refused to use her walker and wheel chair, and fell. The report indicated no injury.</p> <p>-A 7/24/13 BDDS report for a fall on 7/24/13 at 9:55am indicated, client #134 "was walking without walker (sic) in the corridor on first floor, she fell forward, struck her lip. The lip was bleeding and there was blood in her mouth." The record indicated "9-1-1 was notified, client was sent to the hospital for evaluation and treatment." The report indicated "skin glue was applied 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 on her lip" and the hospital diagnosis was "fall, lip laceration, also had bruising to the 4th and 5th fingers on her left hand." The report indicated client #134 "has a pattern of falls without injury associated with a refusal to use her walker or to accept assistance...1:1 (one on one) staffing continues (for supervision) to be in place."</p> <p>-On 7/23/13 at 6:35pm, client #134 was using the toilet and stood up to clean herself and lost balance and fell. No injury was noted.</p> <p>-On 7/23/13 at 1pm, client #134 was "angry," had one on one staff supervision, client #134 refused wheel chair and walker. Client fell and no injury was noted.</p> <p>-On 7/22/13 at 9:20am, client #134 was returning from dining room, forgot to lock her walker, and fell on her buttocks. No injury was noted.</p> <p>-On 7/16/13 no time documented client #134 fell due to refusal to use her walker or wheel chair.</p> <p>-On 7/11/13 at 10am, client #134 was talking, got upset, walked away from staff without her walker, and fell to the floor. No injury was 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 9/5/13 at 10am, client #134's 9/4/13 BDDS report for an incident on 9/4/13 at 12:40pm, indicated client #134 had one on one staff supervision, had become aggressive, was not safe with herself or others, and was sent to the hospital for evaluation.</p> <p>-Client #134's 9/4/13 at 9:15am, investigation note indicated client #134 had "sustained a superficial abrasion to her RUE (right upper extremity) from the shoulder to the elbow" and the client "just fell." After her behavior continued the facility sent her to the hospital for evaluation.</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #134 was at risk to fall and had a history of falling. Administrative staff #2 indicated even with one on one staff and interventions to use a walker and/or wheel chair, client #134 continued to fall. Administrative Staff #2 indicated the investigative component does not determine if the corrective action was effective to address client #134's falls.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated client #134 continued 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 with one on one staff supervision. PD #3 stated if client #134 did not use her walker or wheel chair it would be a "failure" by the facility staff if they did not teach or encourage their use. When asked if client #134's interventions were effective to prevent her from falling, PD #3 indicated client #134 continued to fall.</p> <p>4. A BDDS report dated 8/18/13 was reviewed on 9/3/13 at 2:45 PM and indicated client #2 was taken to the hospital and diagnosed with an elbow fracture. Client #2 "has a subtle crack through part of his elbow fracture, but no treatment is needed." The report indicated staff are "NOT to pull on his left arm or use his left arm for moving him around" and client #2 had a "disorder of bone and cartilage including osteopenia of hip and spine...epilepsy and recurrent seizures...." The report indicated "The fracture is most likely the result of seizure activity. He did have 3 seizures immediately prior to the discovery of the fracture and was noted to be jerking at other times. There were no other identified possible causes. He has seizures both in his bed and in his wheelchair." The report indicated client #2 had padding on his bed rails and "as a safety measure additional padding is being added to his wall and to the metal frame of his wheelchair."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 Fracture Investigation Summary included with the BDDS report regarding client #2's fractured elbow was reviewed on 9/3/13 at 2:40 PM. The report indicated an unidentified CNA (Certified Nurse Aide) "got into his wheelchair and pulled her arms back as happens when he seizures in his chair. Her elbows hit the metal supports of the chair when she pulled her arms back...Nursing did note 3 seizures during the 24 hours immediately preceding the injury." The investigation indicated a care/risk plan specific to fractures is being added to the plans in place addressing seizures, falls, and "risk of injury from falls."</p> <p>Client #2's risk plan for "pain and immobility related to fracture" dated 8/30/13 was reviewed on 9/3/13 at 2:45 PM and indicated in part, "Monitor padding is in place on bed and wheelchair q (each) shift...Provide padding to all corners of the bed, and on metal back of wheelchair."</p> <p>Client #2's risk plan for "Risk for injury related to history of osteopenia" dated 8/30/13 was reviewed on 9/3/13 at 2:46 PM and indicated in part, "Monitor that padding is in place on bed and wheelchair q (each) shift."</p> <p>Observations were completed on the first</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>floor on 9/4/13 from 7:00 AM until 8:10 AM. Client #2 sat in his wheelchair from 7:00 AM until his shower at 7:40 AM. At 7:50 AM, client #2 was brought to the dining room in his wheelchair. There was no padding on the right side of the metal frame of the wheelchair. At 8:00 AM, QDDP (Qualified Developmental Disability Professional) #1 brought the padding for client #2's wheelchair for the right metal frame and attached it to the frame.</p> <p>The QDDP #1 was interviewed on 9/4/13 at 8:00 AM and stated client #2's padding should be on his wheelchair, "all the time. As soon as I saw it, I put it (padding) on."</p> <p>3.1-28(e)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview, the client's Comprehensive Functional Assessment failed to indicate a current behavioral need had been re-assessed for 1 of 15 sampled clients (#6) to determine if changes needed to be made to her plan after she displayed an incident of eating entire sugar packets.</p> <p>Findings include:</p> <p>Client #6's record was reviewed on 9/4/13 at 10:49 A.M. Nursing progress notes dated 8/17/13 indicated "Change of Condition" Situation: "Eating of PICA (eating non-edible items). Client ate a couple of sugar packets." Assessment: "No signs of choking noted, lungs clear to auscultation....Ate 100% (one hundred percent) of breakfast, lunch without difficulty and will continue to monitor." The nursing progress notes indicated client #6 was monitored for any signs or symptoms for at least the next 24 hours. A behavior incident report (BIR) dated 8/17/13 indicated "At 8:00 A.M. on 8/17/13 client (client #6) was walking to the dinning room. Client (client #6) ate an</p>	W000214	<p>W214/W227Monday through Fridays excluding holidays. BSPs are reviewed upon completion and updates. W214I Client 6 has her plan updated to include Pica. The plan will be approved and implemented fully as soon as possible within the constraint of written informed consent and HRC review. II Any resident with Pica may be at risk from this deficient practice. III Residents have been reassessed to determine who may have an issue of Pica and a plan will be developed to address Pica. The plan will be approved and implemented fully as soon as possible within the constraint of written informed consent and HRC review.QMRP staff have been retrained to observe for Pica and Program Directors review behavior incidents for this type of behavior. Any incident of Pica will result in development of a plan to address it. IV Program Directors review behavior information and assure that any incidence of Pica results in a plan to address it. To be completed by October 8, 2013.</p>	10/08/2013
---------	--	---------	---	------------

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>entire sugar package [name of sweetener] packet (Pica)." Client #6's Behavior Support Plan (BSP) dated 11/20/12 indicated she had the targeted behaviors of "agitation, self-injurious behaviors (SIB), stealing (especially food), resistance to medical appointments, and physical aggression." A revised BSP dated 8/13/13 included a new targeted behavior of Public Nudity. The 8/13/13 BSP was currently with client #6's Health Care Representative (HCR) for review and approval. Client #6's record indicated she had a behavior assessment completed on 10/26/12 to assess her agitation, physical aggression and SIB, and another behavior assessment completed on 7/13/11 to assess her physical aggression. There was no assessment available for review to indicate she had been assessed for PICA or reassessed for stealing of food items.</p> <p>An interview was conducted with client #6's Qualified Intellectual Disabilities Professional (QIDP) #4 on 9/5/13 at 9:29 A.M. QIDP #4 indicated client #6 had never displayed any PICA behaviors before, only stealing food. QIDP #4 stated, "It occurred over the weekend in the dining room prior to the meal starting. I just wasn't there so I am not sure how it happened. She moves very quickly and she is supposed to sit back away 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>table until everything is ready, so she will not grab her peer's food. Some staff bring her into the dining room earlier than others. This can make her more anxious to have to sit there and wait. It could have depended on who brought her to the dining room."</p> <p>An interview was conducted with the Program Director (PD) #2 on 9/5/13 at 9:31 A.M. PD #2 stated, "We did not meet as a team since this was her (client #6's) first PICA incident. We are not sure how she managed to get the packet(s) she does move very quickly. We could have her (client #6) come to the dining room later. She is to remain seated back away from the table, but this can cause her more anxiety."</p> <p>PD #2 and QIDP #4 were again interviewed on 9/5/13 at 10:12 A.M. PD #2 and QIDP #4 both indicated client #6 had not been reassessed to see if her plan was meeting her current behavioral needs. PD #2 indicated the behavior assessments in client #6's record were the most recent behavior assessments completed for client #6.</p> <p>3.1-31(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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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. Based on observation, interview and record review for 2 of 15 sampled clients (#2 and #9) and for 1 additional client (#121), the clients' Individual Support Plans (ISPs) failed to address client #2's dining need, and client #9 and #121's identified behavioral needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, Verification Of Investigations (VOIs-facility incident reports) and/or investigations were reviewed on 9/3/13 at 3:10 PM. The facility's reportable incident reports, VOIs and/or investigations indicated the following:</p> <p>-8/17/13 "On 8/17/13 at approximately 9:45 am, a CNA (Certified Nurse Aide) was doing a 15 minute check on [client #121]. [Client #121] was in his room and transferred to his peers (sic) bed and placed his arms around the peer (client #143). Both clients are non verbal and would be unable to report any inappropriate behavior. [Client #121] continues to remain on 15 minute checks.</p>	W000227	<p>W214/W227Monday through Fridays excluding holidays. BSPs are reviewed upon completion and updates.W227Client 2 has a dining goal now to address use of adaptive meal time equipment. His goal has been trained with staff. Client 9 has a plan to address Pica. Client 121 has a plan to address inappropriate social behavior. Needed behavior plans are in process of approval and will be trained as soon as they are through the approval process. II Any client with need of a dining goal, Pica or inappropriate social behavior would be at risk of this deficient practice. III Residents have been reassessed to determine if a dining goal or additional dining goal is needed, plan for Pica or plan to address inappropriate social behavior. QMRPs have been retrained that goals must include training or plans for these issues if deficits exist. When a goal is needed it has been developed and trained with staff. Behavior goals are in process of approval and will be implemented and trained as soon as possible. IV Program Directors assure that deficits are addressed with goals and that Pica is addressed</p>	10/08/2013			

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #121] was moved to the classroom for a bedroom until the IDT (interdisciplinary team) can meet on Monday to determine a placement for [client #121]."</p> <p>The facility's 8/23/13 follow-up report indicated "...[Client #121's] IDT has agreed to add Inappropriate Social Behavior to [client #121's] behavior support plan and add training to teach social boundaries. His current plan will continue to be implemented until the new plan is approved...."</p> <p>-8/28/13 "The clients were in the dining room watching television after having a snack. Another client down the hall had become upset, throwing objects and attempting to assault staff. The CNAs who were in the dining room left to provide assistance. When another CNA returning from her break came into the dining room, she observed [client #121] sitting on [client #143's] lap and kissing his neck. [Client #143] was not pushing [client #121] away, no clothing was removed, and there were no injuries...Patterns and trends were also reviewed. This is the 2nd (second) incident within the month of [client #121] showing affection to [client #143]...His (client #121's) behavior plan is being amended to add Inappropriate Social</p>		with a Behavior Support Plan. Also that inappropriate social behavior is addressed in the clients' plan. To be completed by October 8, 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 to help teach [client #121] social boundaries. 15 minute checks have been reinstated and will continue until the behavior plan revisions have been approved and staff trained. Additionally, staff will be inserviced that, even when responding to a behavioral incident, they are responsible to assure that at least 1 CNA is in the dining room at any time any client is eating or there is more than 1 person in the dining room...."</p> <p>Client #121's record was reviewed on 9/5/13 at 8:38 AM. Client #121's August 2013 Behavior Tally Sheet indicated client #121 demonstrated 3 incidents of "Inappropriate Sexual Behavior."</p> <p>Client #121's Behavior Incident Reports (BIRs) indicated the following (not all inclusive):</p> <p>-8/16/13 "Staff went into room to get client for shower. [Client #121] was in bed with peer under the covers. [Client #121] jumped out of bed. [Client #149] appeared to have been sleep (sic). Nursing notified."</p> <p>-8/17/13 "Staff went into client room. [Client #121] was sitting in [client #143's] bed with his arm around his (client #143's) neck."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>-8/28/13 "[Client #121] was sitting on [client #143's] lap kissing his neck when staff (CNA #60) was coming up from the elevator. Staff asked [client #121] to get up from [client #143's] lap. [Client #121] did as he was told."</p> <p>Client #121's 8/30/13 IDT note indicated "Staff will continue to follow [client #121's] BSP (Behavior Support Plan). Staff will continue to observe [client #121's] behaviors and report all incidents to nursing. Staff will redirect [client #121] when attempting to go in common areas where no staff is present...QDDP (Qualified Developmental Disabilities Professional) will update BSP to include good and bad touch."</p> <p>Client #121's 9/6/12 BSP indicated client #121's BSP did not address the client's identified behavioral need of inappropriate sexual behavior.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) #8 and the Social Worker on 9/5/13 at 10:45 AM indicated clients #121 and #143 were not on the same hallway and/or in the same program room. QIDP #8 and the Social Worker indicated client #121 was in a room by himself. QIDP #8 and the Social Worker indicated client #121 did not have an program/objective 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>which addressed the client's inappropriate sexual behavior as the client's ISP meeting was being held today 9/5/13 at 1:00 PM. QIDP #8 indicated client #121's inappropriate sexual behavior would be added to the client's behavior plan today (9/5/13).</p> <p>2. Observations were conducted on the 2nd floor of the facility on 9/3/13 between 2:30 PM and 6:30 PM. At 5:45 PM client #9 finished eating his evening meal and was escorted to the west hall activity room. At 5:49 PM upon entering the activity room, client #9 was sitting at a table near the window with small blocks in front of him, his mouth closed and chewing on something. LPN #27 and CNA #28 were standing within 2 and 3 feet of client #9 engaged in a conversation with each other and not directly supervising client #9. No other clients were in the activity room at the time. At 5:50 PM LPN #27 and CNA #28 were asked what client #9 had in his mouth. LPN #27 and CNA #28 indicated they did not know and did not see him put anything in his mouth. LPN #27 stated, "He sometimes will pocket food in his mouth, it's probably something he had from his evening meal." LPN #27 put on a pair of gloves and prompted client #9 to open his mouth. Client #9 did not open his mouth. LPN #27 physically 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #27 to open his mouth, performed a finger sweep of client #9's mouth and pulled out a large piece of red foam. CNA #28 picked up a 3 to 4 inch heart shaped piece of foam from the table in front of client #9. The heart shaped piece of foam was missing a large piece. The piece of foam retrieved from client #9's mouth matched the piece missing from the foam shaped heart.</p> <p>Client #9's record was reviewed on 9/4/13 at 10:30 AM. Client #9's BSP (Behavior Support Plan) of 3/14/13 indicated client #9 had a behavior of "Food Stealing: Includes, but is not limited to, [client #9] taking food off the dessert cart when leaving the dining room or taking pudding off the nurses' cart." Client #9's ISP (Individual Support Plan) of 8/14/13 indicated the staff were to check client #9's mouth prior to leaving the dining room to prevent client #9 from pocketing food. Client #9's ISP indicated no objectives to teach client #9 the difference between edible and artificial food items.</p> <p>Interview with LPN #27 and CNA #28 on 9/3/13 at 5:55 PM indicated client #9 had a history of pocketing food. LPN #27 stated, "He (client #9) probably thought it (the piece of foam) was food." When asked if client #9 should have those items around him, LPN #27 stated, "No, 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 supervision." When asked if there were more items in the room similar to the foam heart, CNA #28 retrieved a basket of soft items of assorted shapes from a nearby table in the classroom.</p> <p>During interview with PD (Program Director) #2 on 9/5/13 at 9:15 AM, PD #2 stated client #9 had one incident "about a year ago" of taking a bite out of a piece of plastic fruit and "he (client #9) probably thought it was food." PD #2 indicated client #9 had behaviors of stealing food and pocketing food. PD #2 indicated client #9 did not have a diagnosis of PICA (an eating disorder defined as ingestion of non-nutritive substances). PD #2 indicated the incident was reported to her on 9/3/13 and stated "I thought they observed him (client #9) put it in his mouth and they had him immediately remove it." The PD indicated client #9's ISP and/or BSP did not address client #9's identified behavior of putting non food items in his mouth. PD #2 indicated client #9's ISP did not include an objective to teach client #9 the difference between edible and artificial food items.</p> <p>3. Observations were completed on the first floor on 9/3/13 from 3:05 PM until 5:40 PM. During the evening meal at 5:10 PM, client #2 ate his meal of sandwich, soup and fruit cup with his spoon 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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, spilling food down the front of his clothing protector and on the table.</p> <p>Observations were completed on the first floor on 9/4/13 from 7:00 AM until 8:15 AM. At 7:50 AM, client #2 ate his eggs with his hands and spilled eggs down the front of his clothing protector and on the table. CNA (Certified Nurse Aide) #15 prompted client #2 to use a spoon and client #2 ate his cream of wheat cereal with a spoon. At the conclusion of his meal at 8:10 AM, CNA #15 pushed client #2's wheelchair back, wiped his hands with a napkin and stated, "You've got food everywhere."</p> <p>CNA #15 was interviewed on 9/4/13 at 7:55 AM. She stated client #2 "loved to eat with his hands."</p> <p>Client #2's record was reviewed on 9/4/13 at 1:20 PM. Client #2's Triennial Developmental Evaluation dated 6/3/13 indicated "In the personal area, [client #2] receives a mechanical soft diet with large portions...He usually feeds himself with an adaptive spoon with some spilling. He wears a clothing protector at meal times. If he is not monitored during meal times, he may attempt to grab food with his fingers." Client #2's Individual Support Plan dated 8/6/13 did not include a formal goal to address his dining skills.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 deficiency was cited on 7/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 1 of 15 sampled clients (#9), the client's ISP (Individualized Support Plan) and/or BSP (Behavior Support Plan) failed to address how the staff were to supervise and monitor the client while outside of the dining room for the potential of choking in regard to placing non-edible food items in his mouth.</p> <p>Findings include:</p> <p>Observations were conducted on the 2nd floor of the facility on 9/3/13 between 2:30 PM and 6:30 PM. At 5:45 PM client #9 finished eating his evening meal and was escorted to the west hall activity room. At 5:49 PM upon entering the activity room, client #9 was sitting at a table near the window with small blocks in front of him, his mouth closed and chewing on something. LPN (Licensed Practical Nurse) #27 and CNA (Certified Nursing Assistant) #28 were standing within 2 and 3 feet of client #9 engaged in a conversation with each other and not directly supervising client #9. No other clients were in the activity room at the time. At 5:50 PM LPN #27 and CNA #28</p>	W000240	<p>W240Active treatment audit three times per week by QMRP shows appropriate intervention completed and Program Director and QMRP review behavioral issues daily Monday through Friday excluding holidays which shows absence or presence of behavior. W240I Client 9 has his plan updated to include Pica. The plan will be approved and implemented fully as soon as possible within the constraint of written informed consent and HRC review. II Any resident with Pica may be at risk from this deficient practice. III Residents have been reassessed to determine who may have an issue of Pica and a plan will be developed to address Pica. The plan will be approved and implemented fully as soon as possible within the constraint of written informed consent and HRC review. QMRP staff have been retrained to observe for Pica and Program Directors review behavior incidents for this type of behavior. Any incident of Pica will result in development of a plan to address it. IV Program Directors review behavior information and assure that any incidence of Pica results in a plan to address it. To be completed by October 8, 2013.</p>	10/08/2013	

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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 asked what client #9 had in his mouth. LPN #27 and CNA #28 indicated they did not know and did not see him put anything in his mouth. LPN #27 stated, "He sometimes will pocket food in his mouth, it's probably something he had from his evening meal." LPN #27 put on a pair of gloves and prompted client #9 to open his mouth. Client #9 did not open his mouth. LPN #27 physically prompted client #27 to open his mouth, performed a finger sweep of client #9's mouth and pulled out a large piece of red foam. CNA #28 picked up a 3 to 4 inch heart shaped piece of foam from the table in front of client #9. The heart shaped piece of foam was missing a large piece. The piece of foam retrieved from client #9's mouth matched the piece missing from the foam shaped heart.</p> <p>Client #9's record was reviewed on 9/4/13 at 10:30 AM. Client #9's BSP of 3/14/13 indicated client #9 had a behavior of "Food Stealing: Includes, but is not limited to, [client #9] taking food off the dessert cart when leaving the dining room or taking pudding off the nurses' cart." Client #9's ISP of 8/14/13 indicated client #9 was to have all snacks and drinks in the dining room with staff supervision; diet as ordered, mechanical soft with ground meat consistency. No straws; educate patient and care giver on the safe</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>swallow strategies; may crush appropriate medications for administration; monitor for signs and symptoms of aspiration...." and "staff to check client's (client #9's) mouth before he leaves the dining room to prevent pocketing of food when leaving the dining room...." Client #9's ISP and/or BSP did not indicate how the staff were to supervise client #9 while outside of the dining room for the potential of choking in regard to placing non-edible food items in his mouth.</p> <p>Interview with LPN #27 and CNA #28 on 9/3/13 at 5:55 PM indicated client #9 had a history of pocketing food. LPN #27 stated, "He (client #9) probably thought it (the piece of foam) was food." When asked if client #9 should have those items around him, LPN #27 stated, "No, not without supervision." When asked if there were more items in the room similar to the foam heart, CNA #28 retrieved a basket of soft items of assorted shapes from a nearby table in the classroom.</p> <p>During interview with PD (Program Director) #2 on 9/5/13 at 9:15 AM, PD #2 stated client #9 had one incident "about a year ago" of taking a bite out of a piece of plastic fruit and "he (client #9) probably thought it was food." PD #2 indicated client #9 had behaviors of stealing food and pocketing food. PD #2 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #9 did not have a diagnosis of PICA (an eating disorder defined as the persistent ingestion of non-nutritive substances). PD #2 indicated the incident was reported to her on 9/3/13 and stated "I thought they observed him (client #9) put it in his mouth and they had him immediately remove it." PD #2 indicated client #9's ISP/BSP did not address how the staff were to supervise/monitor client #9 while outside of the dining room for the potential of choking in regard to placing non-edible food items in his mouth.</p> <p>This deficiency was cited on 7/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35 (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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 7 of 15 sampled clients (#1, #2, #3, #4, #5, #10, #14) and 12 additional clients (#19, #23, #28, #29, #31, #33, #63, #66, #68, #69, #130 and #133), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed.</p> <p>Findings include:</p> <p>1. An observation was conducted on the first level on 9/3/13 from 3:00 P.M. until 4:30 P.M.. During the entire observation period, client #19 sat in her room with no activity, client #31 propelled his wheelchair back and forth to and from the day room and clients #28 and #29 sat in their beds with no activity. Clients #1 and #23 sat in their wheelchairs in a line in the hallway outside the day room with no staff interaction or activity. Certified Nursing Aides (CNA) #22, #23 and #24 would walk into the rooms and occasionally check on clients #1, #3 and</p>	W000249	<p>W249Three times per week. The outcome if issues are found is that on the spot education takes place with comments noted by the observer. W249I Clients 1, 2, 3, 4, 5, 10, 14, 19, 23, 28, 29, 31, 33, 63, 66, 68, 69, 130, 133 have had their goals retrained with staff and Active Treatment audits completed by QMRPs to assure that training is taking place. II All residents may be at risk from this deficient practice. III Residents have had their goals retrained with staff and Active Treatment audits completed by QMRPs to assure that training is taking place. IV Program Directors complete regular Active Treatment audits and rounds to assure that goal implementation is completed. To be completed by October 8, 2013.</p>	10/08/2013

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>#4, but did not offer any meaningful activity. During the above mentioned observation period, clients #1, #3, #28 and #29 were non-verbal in communication in that the clients did not speak. No communication training was provided and/or offered to each client. At 4:22 P.M., Nurse #1 began administering client #33's oral prescribed medications. Nurse #1 popped out each of client #33's medications into a small souffle cup and walked the medications to client #33 who was sitting at a table located in the dining room. Review of the Medication Administration Record (MAR) dated 9/2013 and medication labels indicated client #33 received: "Docusate Sodium 100 mg (milligram) capsule, Calcium 600 mg with Vitamin D tablet, Levetiracetam 500 mg tablet, Phenytoin 100 mg capsule, Phenobarbital 32.4 mg tablet." Nurse #1 did not prompt client #33 to identify her medications.</p> <p>A review of client #1's record was conducted on 9/4/13 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..." Review of client #1's "Daily</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Activity Schedule" indicated: Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication."</p> <p>A review of client #2's record was conducted on 9/4/13 at 10:00 A.M.. The ISP dated 8/6/13 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication."</p> <p>A review of client #3's record was conducted on 9/4/13 at 10:10 A.M.. The ISP dated 6/4/13 indicated: "Will stay on task...Will increase interaction with peers...Will enjoy floor time in his room." Review of client #3's "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Toileting and Hygiene, Money Manage."</p> <p>A review of client #4's record was conducted on 9/4/13 at 10:20 A.M.. The ISP dated 2/14/13 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication."</p> <p>A review of client #5's record was conducted on 9/4/13 at 10:40 A.M.. The ISP dated 6/18/13 indicated: "Daily</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication." Client #5's Individual Support Plan dated 2/26/13 indicated he had objectives to come to workshop independently, brush teeth daily, engage in dining etiquette (passing/asking for items, place napkin in lap, sit up straight, wipe mouth/chin w/napkin, etc.), calculate change for a mock purchase, wash clothes once a week, participate in programming with verbal prompting.</p> <p>A review of client #19's record was conducted on 9/4/13 at 10:50 A.M.. The ISP dated 8/1/13 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication."</p> <p>A review of client #23's record was conducted on 9/5/13 at 8:30 A.M.. The ISP dated 12/4/12 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Toileting and Hygiene, Money Goal, Socialization, Recreation."</p> <p>A review of client #28's record was conducted on 9/5/13 at 8:50 A.M.. The Individual Support Plan (ISP) dated 8/14/12 indicated: "Will stay 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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." Review of client #28's "Daily Activity Schedule" indicated: Monday: 3:00 P.M. to 5:00 P.M.: Toileting and Hygiene, Money Management, Communication, Desensitization."</p> <p>A review of client #29's record was conducted on 9/5/13 at 9:10 A.M.. A review of client #29's ISP dated 5/21/13 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting/Hygiene, Money, Communication."</p> <p>A review of client #31's record was conducted on 9/5/13 at 9:15 A.M.. The ISP dated 3/19/13 indicated: "Will attend to task...Will participate in programming activities of choice...Will learn basic banking skills...Will be able to understand the purpose of medications he takes." Review of client #31's "Daily Activity Schedule" indicated: Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose Appropriate clothing/dress, Toileting and Hygiene, Money, Communication."</p> <p>A review of client #33'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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 9/5/13 at 9:15 A.M.. The ISP dated 5/23/13 indicated: "Will identify her pill COLACE by it's color (red)."</p> <p>An interview with Program Director (PD) #1 was conducted on 9/5/13 at 10:22 A.M.. PD #1 indicated facility staff should implement training objectives at all times of opportunity. PD #1 stated "Active treatment should be from when they wake up until they go to bed." The PD further indicated staff should follow clients' daily activity schedules.</p> <p>2. Observations were completed on the first floor from 3:05 PM to 5:40 PM. At 3:05 PM, client #19 took the surveyor by the hand to show her "new room" in room #105 marked with clients #22 and #20's names. At 3:05 PM, Client #19 went into the bathroom in room #105, shut the door, flushed the toilet and ran water in the sink. Client #19 then returned to her room. At 3:06 PM, CNA #17 ran to room #105 and looked for client #19. QDDP (Qualified Developmental Disabilities Professional) #1 was in the hallway and indicated client #19 was not to be in areas where there was water access.</p> <p>Client #19's Behavior Support Plan (BSP) effective 11/29/07 and updated (undated) pending HRC (Human Rights Committee)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>approval was reviewed on 9/4/13 at 3:30 PM. The plan indicated a target behavior of "Excessive Drinking/Cup Hoarding and a diagnosis of polydipsia (chronic excessive thirst and fluid intake). The plan indicated "closely watch her so that she does not engage in excessive water drinking."</p> <p>3. Observations were completed on 9/3/13 from 3:05 PM until 5:40 PM on the first floor. Client #2 was in bed with his eyes closed at 3:06 PM. Client #2 was brought to the west hallway at 3:40 PM. CNA (Certified Nurse Aide) #18 walked with client #2 using a gait belt to the dining room and back from 3:40 to 3:55 PM. Client #2 was returned to his wheelchair with assistance by CNA #18 at 3:55 PM. At 5:10 PM, client #2 was pushed in his wheelchair to the dining room and placed in front of his preset divided plate, utensils and cup.</p> <p>Observations were completed on 9/4/13 from 7:00 AM until 8:15 AM. Client #2 sat in his wheelchair holding a manipulative object from 7:00 AM until 7:16 AM. At 7:16 AM, CNA #16 opened up client #2's dresser drawers and picked out a pair of shorts and a T-shirt to wear, and put on client #2's shoes for him. Client #2 was not offered a choice of clothing to wear. Client #2 was taken 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 dining room in his wheelchair to the dining room and placed in front of his preset divided plate, utensils and cup.</p> <p>Client #2's record was reviewed on 9/4/13 at 1:20 PM. A Pre-Vocational Assessment dated 8/6/13 indicated "Resident can complete the following pre-vocational tasks: ...playing with toys, listening to music, watching TV," and a recommended goal to "stay on task for 5 minutes." The Individual Support Plan dated 8/6/13 indicated objectives included "will participate as much as possible during teeth brushing, will stay on task 5 minutes, will calmly go to the desensitization room, remain fall free, make eye contact with nursing, participate in range of motion exercises, will respond with eye contact when staff calls his name, will walk to dining room for all meals with staff assistance." Client #2's 8/6/13 Daily Activity Schedule indicated at 6:30 AM to 9:00 AM, he was to "choose appropriate clothing/dress, set-up/meal time."</p> <p>4. Observations were completed on 9/3/13 from 3:05 until 5:40 PM. Client #5 was in his room watching TV with his headphones on at 3:30 PM. The QDDP #1 offered activity in another room to client #5 at 3:32 PM, but he declined. Client #4 was in his room lying on his bed. At 4:53</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>PM, client #5 was in his room watching TV. At 5:00 PM, client #5 came to the dining room and sat at a table where his plate, utensils and glasses had been set.</p> <p>During observations on 9/4/13 at 10:31 AM, client #5 was listening to his radio in his room.</p> <p>During observations on 9/4/13 from 9:10 AM until 10:05 PM, clients #4 and #5 rested in their beds without activity. At 9:15 AM, CNA #16 went into clients #4 and #5's room and returned to the hallway.</p> <p>CNA #16 was interviewed on 9/4/13 at 9:15 AM and indicated she had asked clients #4 and #5 if they wanted to go to program, but they declined. She stated they will come to the program room, "sometimes." Clients #4 and #5 lay on their beds sleeping until CNA #19 prompted them to go to the activity room.</p> <p>During observation on 9/4/13 from 12:35 PM until 1:15 PM, client #5 sat on his bed and showed the surveyor his collection of Elvis items and CD/DVD collection and listened to music on his headphones. Clients #4 and #5 indicated they went to workshop Monday through Friday. Client #34 asked client #5 if he had finished his laundry at 12:58 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #4 laid on his bed until 1:00 PM when he went to the restroom. At 1:00 PM, client #4 was asked by an unidentified staff in the hallway if he had a "BM" (bowel movement). At 1:15 PM, client #4 closed his eyes while laying on his bed and client #5 listened to music. No other activity was offered.</p> <p>During observations on 9/4/13 at 2:31 PM, clients #4 and #5 were both laying on their beds with their eyes closed.</p> <p>Client #4 was interviewed on 9/4/13 at 2:31 PM and stated, he "didn't have a chance to go to workshop."</p> <p>Client #5's record was reviewed on 9/4/13 at 2:35 PM. Client #5's Individual Support Plan dated 2/26/13 indicated he had objectives to come to workshop independently, brush teeth daily, engage in dining etiquette (passing/asking for items, place napkin in lap, sit up straight, wipe mouth/chin w/napkin, etc.), calculate change for a mock purchase, wash clothes once a week, participate in programming with verbal prompting. A BSP dated 6/18/13 included a target objective of "Avoidance of Task" defined as refusing to get out of bed during daytime hours, refusal of medications, meals, and hygiene tasks "(relating to diagnosis of Major Depression</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>recurrent)." The BSP indicated client #5 "will receive daily structured programming as well as items and activities to enhance his leisure time," client #2 "will be encouraged to interact positively with staff and peers as often as possible. Behavior Decrease Techniques included for avoidance of tasks, "Communicate with him and try to determine the reason for his refusal, address the concern, counsel [client #5] on the importance of completing the task at hand, ask him again to complete the task, allowing him ample time to begin the task." Client #5's Activity Schedule dated 6/18/13 indicated from 9:00 AM until 11:00 AM, client #5 was to engage in Domestic, Pre-Vocational, Recreational Activity, lunch and meal set up. From 11:30 AM until 3:00 PM, client #5 was to engage in lunch, toileting, Recreational Activity, Nap (optional), AVS (workshop), and snack.</p> <p>A review of client #4's record was conducted on 9/4/13 at 10:20 A.M.. The ISP dated 2/14/13 indicated: "Daily Activity Schedule": "Monday: 3:00 P.M. to 5:00 P.M.: Baths, Choose appropriate clothing/dress, Toileting and Hygiene, Money, Communication." The Daily Activity Schedule indicated from the hours of 9 AM to 11 AM client #4 was to participate in domestic, prevocational</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>training and to participate in a recreational activity. Client #4's activity schedule indicated between 11:30 AM and 3:00 PM client #4 was to eat lunch, toilet, participate in a recreational activity, nap (optional) and snack.</p> <p>The workshop attendance record was reviewed on 9/5/13 at 3:30 PM and indicated clients #4 and #5 were absent on 9/4/13.</p> <p>The Program Director (PD) #1 and QDDP #1 were interviewed on 9/4/13 at 3:40 PM. The PD stated clients #4 and #5 "tend to spend a lot of time in their rooms." She indicated clients #4 and #5 should be prompted to participate in activity every 15 minutes.</p> <p>The PD and QDDP were interviewed on 9/5/13 at 10:55 AM, and when asked about clients #4 and #5 attending workshop on 9/4/13 stated "The Workshop Supervisor said they refused." The PD indicated the workshop supervisor had prompted clients #4 and #5 to attend the workshop on 9/4/13 at 1:15 PM.</p> <p>5. Observations were completed on 9/3/13 from 3:05 PM until 5:40 PM on the first floor. At 3:05 PM, client #3 was asleep in the west hallway sitting in his wheelchair.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 3:20 PM, client #3 sat in the west hallway without activity until 3:55 PM.</p> <p>At 4:01 PM, client #3 was brought to the classroom in his wheelchair and his body slipped down from the seat cushion of the wheelchair with his feet dangling with the backs of his ankles resting on his footrests. At 4:10 PM, client #24 stated to CNA #17 client #3 "was in a bad spot." CNA #17 moved client #3's wheelchair and stated client #3 had to be "so many feet away from the others." No activity was offered. At 4:45 PM, client #3 sat in his wheelchair with his legs dangling, and scooted down from his chair so that the backs of his calves rest against the footrests of his wheelchair until CNA #17 asked client #3 to reposition himself. At 5:10 PM, client #3 was brought to the dining room and had scooted down in the chair so that the back of his calves dangled on the footrests of his wheelchair. At 5:15 PM, client #3 repositioned himself in his wheelchair so that his feet rested on the footrests when CNA #17 prompted the CNA (unidentified) to tilt his wheelchair to assist client #3 to adjust himself. At 5:25 PM, client #3's legs dangled again on top of his foot rests and the unidentified CNA tilted client #3's wheelchair and he readjusted himself so that his feet rested on the footrests of his wheelchair.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 completed on 9/4/13 from 7:00 AM until 8:15 AM on the first floor. Client #3 sat in his wheelchair on the west hall way from 7:00 AM until 7:40 AM with no activity offered.</p> <p>A review of client #3's record was conducted on 9/4/13 at 10:10 A.M.. The ISP dated 6/4/13 indicated: "Will stay on task...Will increase interaction with peers...Will enjoy floor time in his room."</p> <p>The Program Director (PD) #1 and QDDP #1 were interviewed on 9/4/13 at 3:28 PM and indicated clients' objectives should be implemented.</p> <p>The PD was interviewed on 9/4/13 at 3:40 PM again and stated, "It's a tough time before meals," and "There needs to be more action."</p> <p>6. On 9/5/13 from 6:15am until 7:50am, client #63 was in bed asleep. From 7:50am until 8:25am, client #63 was seated in his wheelchair, his pelvic stabilizer was around his waist and strapped to his wheel chair, and the space between the strap and client #63 was four inches. At 8:05am, client #63 was seated in his wheel chair in the classroom with three other clients and no facility staff were present or within eye sight of client #63. At 8:06am, client #63 dropped 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>plastic block on the floor. Client #63 leaned forward in his wheelchair, the front anti tippers of his wheelchair made a clicking noise against the floor, and his wheel chair alarm string dislodged from the control box for the alarm on the back of the wheel chair. At 8:09am, Staff #7 entered the program room from the hallway, reattached client #63's string to the alarm box, and left the room. No staff was within eye sight of client #63. The staff did not pick up the items client #63 dropped to the floor and did not ask client #63 what he needed. From 8:06am until 8:15am, client #63 continued to attempt to pick up the items he dropped on the floor. At 8:15am, client #63 leaned far enough forward again to cause the string on the wheel chair alarm to dislodge from the box and to sound. Staff #7 immediately came into the program room, reconnected client #63's string to the control box for the alarm, and took client #63 out to the hallway in his wheel chair. At 8:20am, client #63 was observed in the hallway. At 8:20am, staff #7 stated client #63 was at risk for falls and was to be supervised within eye sight of the facility staff "at all times" when client #63 was awake. At 8:20am, staff #8 stated client #63 was to be "supervised within eye sight at all times" because client #63 was at risk to fall. Staff #8 stated he applied client #63's pelvic stabilizer today and 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 "loose fitting" on client #63.</p> <p>Client #63's record was reviewed on 9/5/13 at 8:25am. Client #63's 7/2013 Physician Orders indicated "Bed alarm to w/c (wheel chair) and bed while seated and while in bed due transferring (sic) and getting out of bed unassisted for client safety due to unsteady gait and history of falls...May use W/C due to unsteady gait and falls, may utilize gait belt during transfers, may use lap stabilizer while up in w/c for safety."</p> <p>-Client #63's 7/9/13 "Daily Activity Schedule" indicated: "6:30am - 9:00am: Wake up/Bathing, Dressing, Oral Hygiene, Breakfast, hand washing, set up breakfast, meds (medications)." Client #63's record did not indicate what client #63 was to be completing from 7:50am until 8:25am, inside the program room.</p> <p>Client #63's 7/26/13 IDT indicated client #63 had fallen from his wheel chair on 7/25/13 the "team (IDT) implemented the following measures to keep him safe: 1. 15 minutes/checks to monitor and ensure that [client #63] is safe until a comprehensive plan is put in place. 2. [Client #63's] wheel chair has been fitted with front anti tippers to make the new wheel chair more safe. will continue to use a pelvic stabilizer and wheel chair</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>alarm at all times he is on his wheel chair (sic). 3. [Client #63] will be encouraged to seek help to pick up his toys or programming materials from the floor when he drops them...His toys will be placed within his reach and any toys on the floor will be picked up and placed on the table for easy access...15 minute checks were discontinued."</p> <p>On 9/5/13 at 9:45am, an interview with Administrative Staff #2 and Administrative Staff #5 both indicated client #63 was at risk to fall and had a history of falling. Administrative Staff #2 indicated client #63 should have been within eyesight supervision by the facility staff while inside the program room.</p> <p>On 9/5/13 at 10am, an interview with Program Director (PD) #3 was conducted. PD #3 indicated facility staff should be inside the classroom with client #63 and stated "within eyesight" supervision.</p> <p>7. During observations of the medication pass on the 2nd floor of the facility on the west hallway on 9/3/13 between 4 PM and 4:40 PM the following was observed: __At 4 PM LPN (Licensed Practical Nurse) #27 gave client #10 Calcium 600 mg (milligrams) in pudding. LPN #27 offered client #10 no medication training as to the medications the client was taking</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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/or the side effects of the medications.</p> <p>__At 4:15 PM LPN #27 gave client #66 Docusate Liquid (a stool softener) 10 ml (milliliters), Divalproex Sodium (for seizure disorders) 600 mg, Baclofen (for muscle relaxation and spasms) 10 mg and Ferrous Sulfate 325 mg. The LPN stated to client #66, "Here's your medications" and spoon fed client #66 her medications. LPN #27 offered client #66 no medication training as to the medications the client was taking and/or the side effects of the medications.</p> <p>__At 4:25 PM LPN #27 gave client #68 Klor-Con (for low blood potassium) 25 meq (milliequivalents), Valproic acid (for seizures) 250 mg and eye drops. LPN #27 gave client #68 his medications and threw the medication cup in the trash after client #68 had taken his medications. LPN #27 offered client #68 no medication training as to the medications the client was taking and/or the side effects of the medications.</p> <p>__At 4:37 PM LPN #27 gave client #69 Calcium 600 mg with vitamin D, Colace (a stool softener) 100 mg and eye drops. The LPN stated to client #69, "Here's your medications" and spoon fed client #69 her medications. LPN #27 offered client #69 no medication training as to the medications the client was taking and/or the side effects of the medications.</p> <p>LPN #27 prepared each client'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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 at a medication cart in the hallway and individually took each client their medications. LPN #27 did not offer or provide clients #10, #66, #68 and #69 with any training in regard to their medications.</p> <p>Client #10's record was reviewed on 9/4/13 at 9:30 AM. Client #10's ISP of 11/1/12 indicated client #10 was to identify her Potassium pill.</p> <p>Client #66's record was reviewed on 9/5/13 at 9 AM. Client #66's ISP of 7/2/13 indicated client #66 had an objective to cooperate with taking her medications.</p> <p>Client #68's record was reviewed on 9/5/13 at 9 AM. Client #68's ISP of 11/13/12 indicated client #68 had an objective to throw his medication cup in the trash after taking his medication.</p> <p>Client #69's record was reviewed on 9/5/13 at 9 AM. Client #69's ISP of 10/25/12 indicated client #69 had an objective to turn her head toward the nurse to take her medications.</p> <p>Interview with PD (Program Director) #2 on 9/5/13 at 9:15 AM indicated clients were to be offered formal and informal medication training with every medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>pass.</p> <p>8. Client #14 was observed during the 9/3/13 observation period from 2:36 P.M. until 5:30 P.M.. From 3:36 P.M. until 5:30 P.M., client #14 walked around the third floor area of the facility without staff engaging him in meaningful activity or interaction.</p> <p>Client #14's record was reviewed on 9/5/13 at 8:37 A.M.. A review of the client's 8/9/12 Individual Support Plan indicated the client had the following objectives which could have been implemented during the 9/3/13 observation period. "1. Complete two sets of work, 2. Communicate wants and needs using communication board, 3. Write a check for hypothetical purchases, and 4. Straighten up his closet and drawers."</p> <p>9. Client #130 was observed during the 9/4/13 observation period from 4:45 A.M. until 8:45 A.M.. From 4:47 A.M. until 6:09 A.M., client #130 sat alone in program room west 3 north without activity or interaction from staff.</p> <p>Client #130's record was reviewed on 9/5/13 at 8:07 A.M.. A review of the client's 4/13/13 Individual Support Plan indicated the client had the following</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>objectives which could have been implemented during the 9/4/13 observation period. "1. Select coins to match coins set out by trainer, 2. Recognize 3 functional community signs and symbols, 3. Straighten her bedroom clothing areas, and 4. Participate in programming activities with peers."</p> <p>10. Client #133 was observed during the 9/4/13 observation period from 4:45 A.M. until 8:45 A.M.. From 4:47 A.M. until 5:32 A.M., client #133 sat in program room west 3 south without any staff interaction or meaningful activity.</p> <p>Client #133's record was reviewed on 9/5/13 at 8:10 A.M.. A review of the client's 4/13/13 Individual Support Plan indicated the client had the following objectives which could have been implemented during the 9/4/13 observation period. "1. Will operate a mock checking account, 2. Will read a story/article aloud, and 3. Will identify good touch versus bad touch."</p> <p>Program director #3 was interviewed on 9/5/13 at 9:11 A.M.. Program Director #3 stated, "They (clients #14, #130, and #133) should have been offered activity by staff."</p> <p>This deficiency was cited on 7/22/13. 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-23(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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000287	<p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff.</p> <p>Based on observation, record review, and interview, the facility failed to assure 3 additional clients (clients #19, #120, and #132) were not physically blocked from leaving program rooms and bedrooms.</p> <p>Findings include:</p> <p>1. Client #132 was observed during the 9/4/13 observation period from 4:45 A.M. until 8:45 A.M.. At 5:05 A.M., client #132 left her bedroom and began walking down the third floor west wing hallway towards the elevator. CNA (Certified Nursing Assistant) #17, who was taking soiled linen out of client rooms, stopped what she was doing and escorted client #132 to program room west 3 south. CNA #17 then paged the "building float" (floating staff who works where needed) to come to the third floor-west wing. A voice over the loud speaker was heard to say, "Building float on break until 5:25 (A.M.)." Client #132 walked out of program room west 3 south and began walking toward the elevator. CNA #17 escorted client #132 back to program room west 3 south. CNA #17 stood in the</p>	W000287	W287Formal Active Treatment audits completed three times per week. QMRPs are directed to spend at least 50% of their time with their residents. W287I Staff for clients 19, 120 and 132 have been retrained and tested and observed to assure that they are not performing tasks that result in techniques used as a convenience for them. II All residents may be at risk from this deficient practice. III Staff have been retrained, tested and observed to assure that they are not performing tasks that result in techniques used as convenience for them. Training has been added to orientation to address the issue of not performing techniques for convenience of staff. IV Observations are completed by QMRPs, Program Directors and other Administrative staff to assure that staff are not performing tasks that result in techniques used as a convenience for them. If any issues are found, action is taken to re-educate, discipline or suspend and investigation depending on the situation. Training has been added to orientation to address the issue of not performing techniques for convenience of staff.To be	10/08/2013			

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>doorway of program room west 3 south with her arms outstretched and her hands grasping the door frame. Client #132 attempted to exit the program room and CNA #17 blocked the client from leaving and stated, "No, you cannot leave. You need to go sit down." CNA #17 blocked client #132's from exiting program room west 3 south from 5:17 A.M. until 5:24 A.M. when the "building float" staff arrived and began providing activities for client #132 in program room west 3 south. CNA #17 then continued to remove soiled linen from client rooms on the third floor west wing.</p> <p>Client #120 was observed during the 9/4/13 observation period from 4:45 A.M. until 8:45 A.M.. At 5:57 A.M., client #120 left her bedroom and began walking down the hallway toward the elevator. CNA #17 directed the client back to her bedroom. CNA #17 stood in the doorway of client #120's bedroom with her arms outstretched and her hands grasping the door frame. Client #120 attempted to exit her bedroom and CNA #17 blocked the client from leaving her bedroom from 5:57 A.M. until 6:05 A.M. when CNA #17 escorted client #120 to program room west 3 north and provided her with an activity.</p> <p>Client #132's record was reviewed on</p>		completed by October 8, 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 09/05/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>9/5/13 at 8:10 A.M.. A review of the client's 11/15/12 Individual Support Plan and 11/15/12 Behavior Management Plan did not indicate the client was to be physically blocked from leaving the program room.</p> <p>Client #120's record was reviewed on 9/5/13 at 8:18 A.M.. A review of the client's 3/21/13 Individual Support Plan and 6/20/13 Behavior Management Plan did not indicate the client was to be physically blocked from leaving her bedroom.</p> <p>Program Director #3 was interviewed on 9/5/13 at 9:11 A.M.. Program Director #3 stated, "Blocking (clients) by staff standing in the doorway is not allowed."</p> <p>2. An observation was conducted on the first level on 9/3/13 from 3:00 P.M. until 4:30 P.M.. At 3:40 P.M., client #19 walked out of her room into the day room, sat down with her magazines in her lap and began watching television. At 3:55 P.M., Staff #17 entered into the day room and stated "What are you doing in here?" Client #19 got up and stated "I'm going back right now." Staff #17 then stated "Where are you supposed to be? Why are you in here? Why aren't you supposed to be in here?" Client #19 then responded "In my room, because staff has to be 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>here." Staff #17 then stated "You know you are not supposed to be in here unless there are staff here." When staff #17 was asked why client #19 had to stay in her room and could not be in the day room watching television, she responded "There has to be staff in the day room with her."</p> <p>Observations were completed on the first floor on 9/4/13 from 7:00 AM until 8:15 AM. CNA #16 asked clients #19 and #22 to leave the common living area with TV and go to their rooms "because there is no one there." Client #19 indicated she wanted to watch a TV news program. CNA #16 asked client #19 to wait for staff again when she went into the common area at 7:16 AM. The common area did not include a sink or other avenues of obtaining water or other fluids.</p> <p>Client #19's Behavior Management Program effective 11/29/07 and updated pending approval of HRC (Human Rights Committee) approval (undated) was reviewed on 9/4/13 at 3:30 PM. Her plan indicated target behaviors of "Agitation/Temper Tantrum, AWOL" (leaving designated area, i.e., classroom, dining room without permission, verbal aggression, physical aggression and excessive drinking/cup hoarding. The plan did not indicate client #19 was to be restricted to her room. The plan 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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #19 was to be provided with structured with daily structured programming "as well as items and activities to enhance her leisure time."</p> <p>The Program Director (PD) #1 and QDDP (Qualified Developmental Professional) #1 were interviewed on 9/4/13 at 3:28 PM and stated, "It's a tough time before meals and we want them visible." The PD #1 indicated client #19 may have been asked to be in her room because she may have gained access to fluids and had a fluid restriction. She indicated staff were busy at that time of day assisting other clients to dress and prepare for the day and were not available to provide activities to clients in the living area.</p> <p>3.1-3(w)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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</p> <p>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>	W000436	<p>W436Yes padding has been placed on the wheelchair in question. Wheelchairs are checked each shift with problems to be reported when found. W436I Client 2's wheelchair has been checked by P. T. and found to be complete and available for use. II All residents who utilize a wheelchair may be at risk for this deficient practice. III Residents who use a wheelchair have had the wheelchair checked by P. T. to assured they are complete and available for use. Staff have been trained to report issues with adaptive equipment to the Program Director/QMRP. IV CNA assignment sheets include a check each shift for any issues with wheelchairs and method to report those issues as a second method to follow up on any problems with equipment. Staff have been trained on reporting issues with wheelchairs and then information is communicated to Program Director who then requests intervention from P. T. or appropriate source for needed repair or replacement of equipment. Wheelchairs are</p>	10/08/2013

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on observation, interview and record review for 1 of 15 sampled clients (#2), the facility failed to ensure needed adaptive equipment was utilized and/or available for use.</p> <p>Findings include:</p> <p>A BDDS (Bureau of Developmental Disabilities Services) report dated 8/18/13 was reviewed on 9/3/13 at 2:45 PM and indicated client #2 was taken to the hospital and diagnosed with an elbow fracture. The report indicated client #2 had padding on his bed rails and and "as a safety measure additional padding is being added to his wall and to the metal frame of his wheelchair."</p> <p>Client #2's risk plan for "pain and immobility related to fracture" dated 8/30/13 was reviewed on 9/3/13 at 2:45 PM and indicated in part, "Monitor padding is in place on bed and wheelchair q (each) shift...Provide padding to all corners of the bed, and on metal back of wheelchair."</p> <p>Client #2's risk plan for "Risk for injury related to history of osteopenia" dated</p>		checked as part of the Quarterly and Annual meeting process and evaluation as well. To be completed by October 8, 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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>8/30/13 was reviewed on 9/3/13 at 2:46 PM and indicated in part, "Monitor that padding is in place on bed and wheelchair q (each) shift."</p> <p>Observations were completed on the first floor on 9/4/13 from 7:00 AM until 8:10 AM. Client #2 sat in his wheelchair from 7:00 AM until his shower at 7:40 AM. At 7:50 AM, client #2 was brought to the dining room in his wheelchair. There was no padding on the right side of the metal frame of the wheelchair. At 8:00 AM, QDDP (Qualified Developmental Disability Professional) #1 brought the padding for client #2's wheelchair for the right metal frame and attached it to the frame.</p> <p>The QDDP #1 was interviewed on 9/4/13 at 8:00 AM and stated client #2's padding should be on his wheelchair, "all the time."</p>	W009999	The 2567 contained no text in 9999, therefore, no plan of correction is formulated. Thank you	10/08/2013			