

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for a post-certification revisit survey (PCR) to the pre-determined full recertification and state licensure survey. This visit included the PCR to the investigation of complaint #IN00113231 completed on 8/17/12.</p> <p>This visit was in conjunction with the investigation of complaint #IN00115538.</p> <p>This visit was in conjunction with a PCR to the PCR completed on 8/17/12 to the PCR completed on completed on 6/29/12 to the investigation of complaints #IN00108475 and #IN00107965 completed on 5/23/12. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00113231-Not Corrected.</p> <p>Dates of Survey: 9/25, 9/26, 9/27 and 10/2/12</p> <p>Facility number: 000622 Provider number: 15G079 AIM number: 100272170</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, RN, Public Health Nurse Surveyor (9/25/12 to 9/27/12)</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Dotty Walton, Medical Surveyor III (9/25/12 to 9/27/12)</p> <p>Mark Ficklin, Medical Surveyor III (9/25/12 to 9/27/12)</p> <p>Steven Schwing, Medical Surveyor III (9/25/12 to 9/27/12)</p> <p>Keith Briner, Medical Surveyor III (9/25/12 to 9/27/12)</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 10/11/12 by Ruth Shackelford, Medical Surveyor III.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0136	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on record review and interview for 12 of 16 sampled clients (#1, #2, #3, #4, #6, #7, #8, #9, #10, #13, #15 and #16), the facility failed to provide the clients with outings or community activities on a regular and ongoing basis.</p> <p>Findings include:</p> <p>1. The facility's community outing log was reviewed on 9/26/12 at 9:45 AM. The review indicated the following community based outing/activities regarding clients #1, #2, #3 and #4:</p> <p>-August 2012: Client #1: 8/29/12, community outing. Client #2: 8/29/12, community outing Client #3: 8/29/12, community outing Client #4: 8/13/12, community outing</p> <p>-September 2012: Client #1: 9/19/12, community outing Client #2: 9/13/12, community outing Client #4: 9/21/12, community outing</p> <p>Interview with AS (Administrative Staff)</p>	W0136	<p>Plan of Correction Golden Living North Willow 10-2-12 follow up surveys</p> <p>W136 Protection of Client Rights</p> <p>The following plan of correction was submitted in response to the 8-17-12 site of W136</p> <p>W136</p> <p>I A policy for Community integration has been drafted and will be followed for the residents named in less than adequate outings. Residents 2, 4, 6, 7, 8, 9, 10, and 16 have outings scheduled for September that are adequate. The QMRP responsible for those residents has been retrained of that important requirement. If a resident did not attend an IDT has been completed outlining the corrective action as per policy.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III QMRPs have been trained on the Community Integration Policy.</p> <p>IV Program Directors report monthly assuring that each</p>	11/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#5 on 9/27/12 at 10:15 AM indicated the facility was sending clients on outings minimally one time a month.</p> <p>2. Client #6's record was reviewed on 09/26/2012 at 11:14 a.m. The community outing log indicated client #6 had not participated in a community activity during the first 26 days of September 2012.</p> <p>Client #7's record was reviewed on 09/26/2012 at 1:08 p.m. The community outing log indicated client #7 had not participated in a community activity during the first 26 days of September 2012.</p>		<p>resident attends outings and when they did not attend and an IDT is presented that outlines reasons with corrective action per the Community Integration Policy.</p> <p>This plan was accepted by Indiana State Department of Health as evidenced by the unsigned letter dated 9-11-12 states the POC of 8-17-12 was accepted on 9-6-12.</p> <p>The Community Integration policy of Golden Living North Willow has been reviewed by the management team and was revised on 10-17-12. You will find that policy in attachment to this plan of correction. In review of regulations there is no specified number of activities or outings required to meet the regulation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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's record was reviewed on 09/26/2012 at 9:36 a.m. The community outing record indicated client #9 went to a department store on 09/09/2012. The record did not indicate additional community outings/activities during the first 26 days of September 2012.</p> <p>A September 1, 2012 policy, titled, "Community Integration," was reviewed on 9/26/12 at 11 AM. The policy indicated, "...Residents participate in at least one outing monthly. When the resident does not attend a scheduled outing, an IDT (Interdisciplinary Team) outlines the reasons they chose not to attend and how the issue will be addressed. Outings will vary with weather and interests of the resident. Group outings may be taken and small groups are encouraged...."</p> <p>During an interview on 09/26/2012 at 11:02 a.m., Administrative staff #6 stated, "Policy for community outings is once a month."</p> <p>During an interview on 09/26/2012 at 11:34 a.m., Qualified Developmental Disabilities Professional (QDDP) #3 indicated clients #6 and #7 had not been in the community during September 2012. She indicated each were scheduled to go on a community outing to a fast food</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>restaurant on 09/28/2012.</p> <p>3. On 9/26/12 at 2:50 PM client #13 and #15's trip calendars were reviewed since August 18, 2012. Interview with Administrative Staff #7 on 9/26/12 at 2:50 PM indicated clients #13 and #15 were scheduled for trips to local restaurants later in the week; but had not been on outings at the time of the record review and interview.</p> <p>4. A review of client #8's community outings binder was conducted on 9/27/12 at 10:36 AM. Client #8 attended one outing in September 2012 (on 9/13/12) to a park.</p> <p>A review of client #10's community outings binder was conducted on 9/27/12 at 10:36 AM. Client #10 attended one outing in September 2012 (on 9/11/12) to a park.</p> <p>A review of client #16's community outings binder was conducted on 9/27/12 at 10:36 AM. Client #16 attended one outing in September 2012 (on 9/11/12) to a park.</p> <p>An interview was conducted with Administrative Staff (AS) #6 on 9/27/12 at 12:07 PM. AS #6 indicated the expectation for community outings was a minimum of one outing per month. AS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#6 indicated the minimum of one outing per month met the facility's policy for community outings.</p> <p>This deficiency was cited on 8/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-3(m) 3.1-3(u)(1) 3.1-3(u)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed for 4 of 9 allegations of client abuse/neglect reviewed (clients #12, #13, #14), to implement policy and procedures to prevent reoccurrence of client elopement, a client to client incident which resulted in an elopement, and to thoroughly investigate reported injuries of unknown origin.</p> <p>Findings include:</p> <p>1. Review of the facility's incidents/investigations was done on 9/25/12 at 4:12p.m. The following investigations were reviewed: 1. On 8/25/12, client #12 had a behavior with agitation in the dining room and was escorted by staff to her bedroom to calm down. The report indicated facility staff did not monitor client #12 while she was agitated and was in her bedroom to calm herself. The report indicated client #12 was to be observed closely during agitation due to this being an antecedent to her elopement behavior. Client #12 was reported to have eloped from the 3rd floor without staff knowledge including the 3rd floor hall monitor. Client #12 had exited the building on the 1st floor west</p>	W0149	<p>W149 Staff Treatment of Clients 1. Client 12 has had her Behavior Support Plan, BSP, competency tested with staff. 2. Client 12 has had her Behavior Support Plan, BSP, competency tested with staff. 3. The file for state reportable incident of an unknown injury to Client 12 on 8-29-12 was reviewed and updated to include more information that was remiss during the survey visit and review on 9-28-12. This investigation was completed prior to the plan of correction completion date of 9-16-12. The approved plan of correction for W154 is being followed with reportable unknown injury of client's thoroughly investigated. W154 The agency has policies in place to assure alleged violations are thoroughly investigated. (from previous POC 8-17-12) For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries</p>	11/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>exit which caused an alarm to sound and alert 1st floor staff. The facility 1st floor staff returned client #12 to the 3rd floor.</p> <p>2. On 9/15/12, client #12 had a behavior with agitation in the dining room and was escorted by staff to her bedroom to calm down. Staff did not monitor client #12 while she was agitated and was in her bedroom to calm self. Client #12 was reported to have eloped from the 3rd floor without 3rd floor staff knowledge including the 3rd floor hall monitor. Client #12 had exited the building on the 1st floor west exit which caused an alarm to sound and alert 1st floor staff. The facility 1st floor staff returned client #12 to the 3rd floor.</p> <p>3. On 8/29/12, client #12 was reported to have a 1cm (centimeter) by 4cm bruise of unknown origin to her right lower back. The bruise was discovered and reported on 8/29/12 by direct care staff #30. Staff #30 had assisted client #12 with bathing on 8/29/12. The investigation did not have documented interviews of facility staff, including the staff who had discovered the bruise, for the possible origin of the unknown injury.</p> <p>Record review for client #12 was done on 9/28/12 at 9:52a.m. Client #12 had a BSP dated 11/3/11. The BSP indicated client</p>		<p>of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. II All residents of North Willow have the potential to be harmed by the deficient practice. III In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. Client 12 has had her Behavior Support Plan, BSP, competency tested with staff.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#12 displayed the behavior: elopement. The BSP indicated agitation was often an antecedent for elopement. The BSP for agitation indicated "staff should verbally prompt [client #12] to stop and direct her to a quiet area to calm." The BSP indicated client #12 "should be closely monitored while having quiet time to calm down. Staff should be in view of the quiet area at all times to ensure that [client #12] does not attempt to elope."</p> <p>Administrative staff #7 was interviewed on 9/26/12 at 9:38a.m. Administrative staff #7 indicated client #12 had eloped from the 3rd floor on 8/25/12 and on 9/15/12. Both elopements had occurred after client #12 was agitated in the dining room and had been directed by staff to her bedroom to calm. During both elopements staff did not observe client #12 in her bedroom until calm. Staff #7 indicated client #12's current behavior support plan (BSP), dated 11/3/11, indicated when client #12 was agitated and calming self in her bedroom, client #12 was to be observed by staff until calm to prevent elopement. Administrative staff #7 indicated staff had been retrained on the BSP following the 8/25/12 elopement. Staff #7 indicated facility staff had not followed client #12's BSP to prevent elopement on 8/25/12 and on 9/15/12.</p>		<p>4. Client 14's BSP has been reviewed and updated. Competency based testing for this BSP has been completed with staff. (or will be completed upon Written Informed Consent and approval of the Human Rights Committee which may not be prior to follow up). II All residents of North Willow have the potential to be harmed by the deficient practice. III 1. Staff will be competency tested on BSPs for the resident's on their regularly assigned hall by 12-31-12 and then quarterly thereafter. 2. Staff will be competency tested on BSPs for the resident's on their regularly assigned hall by 12-31-12 and then quarterly thereafter. 3. W154 I The agency has policies in place to assure alleged violations are thoroughly investigated. (from previous POC 8-17-12) For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. II All residents 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 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #3 was interviewed on 9/26/12 at 3:44p.m. Administrative staff #3 indicated an investigation had been done for client #12's reported injury of unknown origin on 8/29/12.</p> <p>Administrative staff #3 indicated the investigation did not include any documented staff interviews.</p> <p>Administrative staff #3 indicated the investigation (per the facility policy) should have included documented interviews of facility staff to help determine the cause of the injury of unknown origin.</p> <p>The facility's policy and procedures were reviewed on 9/26/12 at 4:44p.m. The policy, dated 5/01 and updated on 4/13/12, "Reporting Alleged Violations" indicated "It is the policy of this facility to take appropriate steps to prevent the occurrence of neglect and injuries of unknown source." The policy identified neglect as "neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The policy indicated "the investigation includes interviews of associates, visitors or residents who may have knowledge of the alleged incident." The policy indicated "An injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event."</p>		<p>North Willow have the potential to be harmed by the deficient practice. III In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. 4. Staff will be competency tested on BSPs for the resident's on their regularly assigned hall by 12-31-12 and then quarterly thereafter. IV. 1. Program Directors will assure competency based testing of BSPs by 12-31-12 and then</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	The policy indicated "Appropriate steps are taken to prevent recurrence of the incident."		<p>quarterly thereafter as specified.</p> <p>2. Program Directors will assure competency based testing of BSPs by 12-31-12 and then quarterly thereafter as specified.</p> <p>3. W154 I The agency has policies in place to assure alleged violations are thoroughly investigated. (from previous POC 8-17-12) For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed, regardless of verbal skills, to determine any additional information. II All residents of North Willow have the potential to be harmed by the deficient practice. III In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates. For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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. Facility incidents and investigations were reviewed on 9/25/12 at 3:00 PM. The review indicated an investigation dated 9/7/12 by Administrative staff #4 regarding an incident on 8/31/12 at 8:10 AM between clients #13 and #14. The 9/7/12 investigation indicated the following: "Summary of Incident: [Client #13] reported that when he got up, he had seen that [client #14] had torn a button off a pair of his jeans. He got angry and threw the jeans. He attempt (sic) to assault [client #14] and hit him on the back with</p>		<p>interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury. At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff. IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover sheets in the hard files, investigation summary reports will be emailed to the Executive Director. 4. Program Directors will assure competency based testing of BSPs by 12-31-12 and then quarterly thereafter as specified.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>a rubber shoe. When staff tried to intervene, he assaulted staff, hitting, kicking, scratching and breaking her glasses. When it was time for breakfast, he again tried to hit [client #14], tried to take a chair from [client #14] and assaulted staff again. Asssitance (sic) was called for and [client #13] eloped down the west hall. When this writer went out side (sic) in response to the Code Green (facility wide call for staff assistance), (client #13) and 4 staff were across the street in the parking lot of the building. Staff were trying to redirect him back into the building and he refused, attempting multiple times to run from staff and running towards [name of] St (a busy four lane city thoroughfare). When he was getting close to the intersection of the side street with [name of] St, staff did reach out and grab him by the shirt to stop him. They were able to bring him back to the building using a 2 person escort with the remaining staff following close by. [Client #13] continued to try to bite, kick and hit staff. At the doors to the building, he sat down on the ground and required an escort to go in the building. In the building he sat back down, continued to try to assault staff and elope. He pulled a plaque off the wall, slammed it down to the ground breaking the wood. He was offered a glass of water which he took and then threw to the ground. He agreed 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 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>return upstairs, but at the elevator, sat back down and tried to elope and assault staff again. The ADON (Assistant Director of Nurses) called for police assistance. [Client #13] did calm enough to go upstairs and once in his room, accepted a glass of water from the social worker and agreed to talk to this writer. His room was searched and a glass cross was removed. The police arrived and talked to [client #13] but did not arrest him. His psychiatrist was contacted who directed the agency to call the police again if [client #13] AWOL/eloped and to request that he be transported to [local hospital stress unit] for an immediate detention order."</p> <p>The investigation indicated those two clients had three "altercations" in the past three months prior to this incident. The incident investigation indicated client #13 and #14 had Behavior Support Plans/BSPs. Client #13's BSP dated 3/12 indicated his maladaptive behaviors included physical assault, property destruction, AWOL/elopement, agitation, and temper tantrums. Client #14's BSP dated 8/15/11 indicated he had the maladaptive behaviors of agitation (a frequent antecedent to property destruction), property destruction (which included stealing clothing), physical assault, inappropriate sexual behavior, sexual aggression, and AWOL/elopement.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 investigation concluded client #14's taking of client #13's jeans precipitated the incident. Client #13's behaviors "escalated as has happened historically."</p> <p>The investigation recommendations component indicated the two clients had three episodes of "conflict" in the past three month period. The clients' behavior interventions should continue to be implemented by staff.</p> <p>Review on 9/26/12 at 4:45 PM of the agency's Nursing Policies and Procedures indicated the "Reporting Alleged Violations" procedure with revision date of April 13, 2012. The procedure indicated the agency promoted the welfare and protection of individuals and took steps to prevent the occurrence of : "abuse...willful infliction of injury...the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being. Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Misappropriation of resident property means the deliberate...wrongful...use of a resident's belongings...without the resident's consent." The procedure indicated the agency implemented corrective actions regarding substantiated incidents of abuse, neglect</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>or misappropriation of residents' personal property: "Appropriate steps are taken to prevent recurrence of the incident. This may include inservices or other measures as appropriate...."</p> <p>Interview with Administrative staff #3 on 9/26/12 at 4:05 PM indicated client #14 had a history of going into his peers' rooms, taking clothing and tearing it up. The interview indicated client #13 had a history of physical aggression. The interview indicated if client #14 had been adequately supervised by staff the incident of 8/31/12 may have been avoided.</p> <p>This federal tag relates to complaint #IN00113231.</p> <p>This deficiency was cited on 8/17/12. 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 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W0154	<p>W154</p> <p>The file for state reportable incident of an unknown injury to Client 12 on 8-29-12 was reviewed and updated to include more information that was remiss during the survey visit and review on 9-28-12. This investigation was completed prior to the plan of correction completion date of 9-16-12. The approved plan of correction for W154 is being followed with reportable unknown injury of client's thoroughly investigated.</p> <p>W154</p> <p>I The agency has policies in place to assure alleged violations are thoroughly investigated.</p> <p>(from previous POC 8-17-12) For injuries of unknown origin for clients #15, #93 and #148, the agency will review internal incident reports (BIRs), nursing notes, nursing verification of investigation (DQI), and nursing change of status notes (Sbars) for the 72 hour period preceding the injury. Patterns and trends will be reviewed to determine if there is a history or common factor relating injuries or injuries of unknown origin. Clients #15, #93 and #148 will be interviewed,</p>	11/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>regardless of verbal skills, to determine any additional information.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III In the future, documentation review specified above will be completed for all injuries of unknown origin. The template used to write investigation summaries will be modified to include prompts to include these items. To be completed by Client Advocates.</p> <p>For all injuries of unknown origin, the client advocates or designee will assure that the individual, regardless of verbal communication skills, is interviewed. The template will be modified to include a prompt specifically to interview the individual with the injury.</p> <p>At least 1 staff member from each shift for the 72 hours preceding discovery of the injury will be interviewed. The template will be modified to include a prompt specifically to interview these staff.</p> <p>IV Oversight will include Executive Director review of all incidents and investigation summaries for completeness. In addition to signing off on cover</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 record review and interview, the facility failed for 1 of 8 incidents of alleged neglect and injuries of unknown origin (client #12) to ensure that all injuries of unknown origin are thoroughly investigated.</p> <p>Findings include:</p> <p>Review of the facility's incidents/investigations was done on 9/25/12 at 4:12p.m. The following investigation was reviewed: On 8/29/12, client #12 was reported to have a 1cm (centimeters) by 4cm bruise of unknown origin to her right lower back. The bruise was discovered and reported on 8/29/12 by direct care staff #30. Staff #30 had assisted client #12 with bathing on 8/29/12. The investigation did not have documented interviews of facility staff, including the staff who had discovered the bruise, for the possible origin of the unknown injury.</p> <p>Administrative staff #3 was interviewed on 9/26/12 at 3:44p.m. Administrative staff #3 indicated an investigation had been done for client #12's reported injury</p>		<p>sheets in the hard files, investigation summary reports will be emailed to the Executive Director.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of unknown origin on 8/29/12. Administrative staff #3 indicated the investigation did not include any documented staff interviews. Administrative staff #3 indicated the investigation should have included documented interviews of facility staff to help determine the cause of the injury of unknown origin.</p> <p>This deficiency was cited on 8/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(d)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 16 sampled clients (#12, #14, #15) to ensure client #12's individual support plan (ISP) had training programs in place to address the identified need of pedestrian safety skills and clients #14 and #15's mealtime and toileting skills/needs.</p> <p>Findings include:</p> <p>1. Review of the facility's incidents/investigations was done on 9/25/12 at 4:12p.m. The following investigations were reviewed: on 8/25/12 and on 9/15/12, client #12 had a behavior with agitation in the dining room and eloped out of the building to the front parking area. Record review for client #12 was done on 9/28/12 at 9:52a.m. Client #12 had an 11/11/11 ISP. Client #12's 11/10/11 functional skills assessment indicated client #12 had training needs with pedestrian safety skills and skills with identifying her address/phone number. Client #12's ISP did not address her identified pedestrian safety needs.</p>	W0227	<p>W227</p> <p>I Client 12's IDT has implemented a pedestrian skills objective for them. Client 14's IDT has implemented a dining goal for them and Client 15's IDT has implemented a dining and toileting goal for them.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Residents have been assessed by the IDT for need of mealtime and toileting goals and for those needing goals those have been implemented by the IDT. Residents who have the behavior of elopement have been assessed for the need of pedestrian skills and for those needing it a goal has been implemented.</p> <p>IV Program Directors in review of plans, ISP, BSP assure that needed toileting, mealtime and for those with issues of elopement assure these issues have been addressed appropriately.</p>	11/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 #7 was interviewed on 9/26/12 at 9:38a.m. Staff #7 indicated client #12 had eloped out of the building on 8/25/12 and on 9/15/12. Staff #7 indicated client #12 was in need of pedestrian safety skills. Staff #7 indicated client #12 did not have training programs in place to address the identified need for pedestrian safety skills.</p> <p>2. During observations at the facility on 9/25/12 from 4:55 PM until 5:18 PM client #15 had his evening meal. Client #15 ate the meal (meat patties, cabbage casserole, potatoes Au gratin and jello) in a fast pace. The client pushed the food onto his spoon with his right hand. Client #15 accelerated his eating pace when direct contact staff #2 left the table to get serving spoons and napkins. Client #15 did not cut his meat patties. Client #15 ate it by scooping it onto his spoon and eating bites off the entire patty. Client #15 overfilled his 8 ounce glass, spilling soda on the table when offered a 20 ounce bottle. Client #15 drank the soda in a fast manner. Staff #2 did not offer mealtime training to client #15.</p> <p>Client #14 ate dinner on 9/25/12 at 5:45 PM. Client #14 served himself 3 beef patties and a large unmeasured amount of potatoes augratin. The client ate in a fast</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>manner without cutting the meat. Client #14 served himself more potatoes and two more beef patties. He helped himself to a large serving of jello. Client #14 went to the serving steam table for more food. Staff #3 assisted client #14 with getting another beef patty and more potatoes. Client #14 ate this and also had 2 slices of bread along with a bottle of lemonade.</p> <p>Review of client #14's record on 9/26/12 at 3:02 PM indicated an ISP/Individual Support Plan dated 10/11/11. The ISP contained no mealtime training goal to address client #14's portioning, manners, or rate of consumption.</p> <p>Review of client #15's record on 9/26/12 at 2:00 PM indicated an ISP/Individual Support Plan dated 03/28/12. The ISP contained no training for client #15 in regards to indicating to staff when he needed to use the restroom or other skill development in that area. The ISP contained no training in mealtime skills of cutting food, serving himself food beverages appropriately or slowing his rate of eating.</p> <p>Interview was conducted with Administrative Staff #7 on 9/27/12 at 10:08 AM. The interview indicated client #14 did not have a mealtime training objective. The interview indicated client</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#15 did not have training goals in toileting and mealtime. 3.1-35(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review, the facility failed to ensure restrictive interventions were part of the clients' Individual Support Plans/Behavior Support Plans (ISPs/BSPs) for 4 of 14 programs reviewed for restrictive interventions for 4 of 16 sampled clients (clients #7, #10, #14, and #16).</p> <p>Findings include:</p> <p>1. Client #7's record was reviewed on 09/26/2012 at 1:08 p.m. The "Patient Notes Master," dated, 07/16/2012, indicated, "...Special needs-slight anxiety/combatative pt (patient) was presedated by home (facility) -(sic) with Halcion .25 mg (milligrams) 3 tabs (tablets)...Pt. was wrapped in Rainbow (a wrap that restricts movement of the body) and stabilized...Pt. was manageable but intermittently moved head. Four handed dentistry (restraint/physical hold) was sufficient to stabilize pt. and complete treatment...."</p>	W0289	<p>W289</p> <p>I Clients 7, 10, 14 and 16 will have had a dental restraint assessment completed when they have a dental appointment. Not all residents will have had a dental appointment prior to follow up visit. The assessment contains what restraints are utilized, the amount of time the restraint was applied and the resident's reaction to the restraint. An IDT, Addendum to the ISP has been completed which addresses and explains the types of restraint used. A BSP to address restraint during medical procedures has been developed and is in process of obtaining written informed consent and HRC approval. Desense goals have been reviewed and revised to include a more comprehensive approach to training. A sample will be attached to this POC.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Any resident with dental restraints will have had a dental</p>	11/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A Dental assessment, dated, 09/10/2012, indicated, " ...The Dentist will document what type of restraint may be needed and a Written Informed Consent (WIC) obtained with HRC (Human Rights Committee) approval prior to the dental visit. When an attempt is made a WIC will be obtained for any needed restrictions and the attempted decrease will be noted. The Dentist will note on the consult whether the decrease was successful or not and recommendation for restraint at future appointments."</p> <p>The Individual Support Plan (ISP), dated 02/14/2012 and/or the Behavior Support Plan (BSP) dated 01/13/2012 did not indicate the use of 4 handed dentistry.</p> <p>During an interview on 09/26/2012 at 2:10 p.m., Administrative staff #6 indicated client #7's ISP/BSP had not been updated to include 4 handed dentistry and a plan for reducing the restriction.</p>		<p>restraint assessment completed when they have a dental appointment. Those with a dental appointment scheduled by 12-31-12 will have their plans completed by POC due date. Other resident's plans will be completed by March 31, 2013. The desense plans will be completed on each resident. The assessment contains what restraints are utilized, the amount of time the restraint was applied and the resident's reaction to the restraint. An IDT, Addendum the ISP has been completed which addresses and explains the types of restraint used. A BSP to address restraint during medical procedures has been developed and is in process of obtaining written informed consent and HRC approval. Desense goals have been reviewed and revised to include a more comprehensive approach to training. A sample will be attached to this POC.</p> <p>IV Program Directors assure that the residents with dental restraints used have an assessment completed at time of dental appointment and IDT completed which addresses and explains the types of restraint used. Not all residents will have had a dental appointment prior to follow up visit Program Director's also assure a BSP to address restraint during medical procedures has been developed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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. Review of client #14's record on 9/26/12 at 3:02 PM indicated a BSP/Behavior Support Plan dated 8/15/11. The record also contained an ISP/ Individual Support Plan dated 10/11/11 with accompanying assessment/FSA dated 10/12/10. The assessment indicated client #14 required the use of pre sedation (Halcion 0.25 milligrams 2 tablets used for conscious sedation) 30 minutes prior to dental appointments and the use of a "rainbow wrap" (body covering mechanical type restraint) during dental procedures. Interview with Administrative staff #7 on 9/26/12 at 4:00 PM indicated another assessment (undated) had been completed for client #14 as pertaining to dental procedures. The assessment (reviewed</p>		<p>and is in process of obtaining written informed consent and HRC approval. Desense goals have been reviewed and revised to include a more comprehensive approach to training. A sample will be attached to this POC. Any resident with dental restraints will have had a dental restraint assessment completed when they have a dental appointment. Those with a dental appointment scheduled by 12-31-12 will have their plans completed by POC due date. Other resident's plans will be completed by March 31, 2013.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>9/27/12 at 4:15 PM) indicated client #14 required the use of "being physically/chemically/mechanically restrained when receiving any type of medical/dental care." The record review of client #14's ISP, BSP and assessments contained no information regarding the length of time the client was sedated/restrained, how he responded to the sedation/restraint, and there was no implementation of methodology to decrease the dependence upon the sedation/restraint during the dental procedures.</p> <p>3. A review of client #10's record was conducted on 9/26/12 at 11:21 AM. Dental records from 10/17/11 and 6/25/12 indicated the following, "Pt (patient) was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment." There was no documentation in client #10's record indicating a description of four handed dentistry. There was no plan addressing four handed dentistry. A review of client #10's Behavior Plan, dated 2/2/12, indicated there was no documentation addressing the use of four handed dentistry. Client #10's Individual Support Plan (ISP), dated 2/2/12, did not address the use of four handed dentistry.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A review of client #16's record was conducted on 9/26/12 at 9:49 AM. A dental record dated 1/30/12 indicated, in part, "Pt was wrapped in Rainbow and stabilized. Pt was manageable but intermittently moved head. Four handed dentistry was sufficient to stabilize pt and complete dental treatment. Therefore, recommend using the same pre-sedation to control pt's behavior to provide dental treatment." There was no documentation in client #16's record indicating a description of four handed dentistry. There was no plan addressing four handed dentistry. A review of client #16's Behavior Plan, dated 3/22/12, indicated there was no documentation addressing the use of four handed dentistry. Client #16's ISP, dated 3/22/12, did not address the use of four handed dentistry.</p> <p>During an interview on 09/26/2012 at 2:10 p.m., Administrative staff #6 indicated the clients' ISP/BSPs had not been updated to include 4 handed dentistry and a plan for reducing the restriction.</p> <p>This federal tag relates to complaint #IN00113231.</p> <p>This deficiency was cited on 8/17/12. The facility failed to implement a systemic plan of correction to prevent</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recurrence. 3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (#8 and #9) and for 5 additional clients (#17, #24, #73, #88 and #89), the facility's nursing services failed to ensure: 1) the facility's policy for administering medications in the dining room was implemented, as written, for client #89, 2) the Medication Administration Record (MAR) was immediately initialed after clients #8, #9, #73, #88 and #89 received their medications, and 3) the policy for the destruction of clients #17 and #24's medications was implemented.</p> <p>Findings include:</p> <p>1) An observation was conducted on the second floor of the facility on 9/25/12 from 4:24 PM to 6:08 PM. On 9/25/12 at 4:30 PM, nurse #39 prepared client #89's medications (Calcium Carb for nutritional supplement, Colace for constipation, Divalproex for seizures, Simethicone for gas, and Tegretol for seizures) for administration. Nurse #39 put the medications into a cup and mixed them with ice cream. At 4:42 PM, nurse #39 attempted to administer the medications to client #89. Client #89 drank three</p>	W0331	<p>W331</p> <p>I 1. Client 89 will have their medications given per amended policy for Medication Administration which states <i>Medication can be administered in the Dining Room before residents actively begins to eat their meal or after completion of their meal. Medications should NOT be given while the client is eating their meal unless ordered by Physician medications is to be given with meal. Medication may also be given in the hallway, nurses station, resident's room or any other designation that is requested by the resident.</i></p> <p>2. Client 89, 8, 9, 73, and 88's nurse #40 was recalled to North Willow and initialed the MAR on 9-25-12 per DNS request. The DNS prepared a discipline for nurse #40 regarding failure to document on the MAR and it was not given due to her departure prior to administration.</p> <p>3. Client 17 and 24's nurse, #11 has been retrained on the drug destruction policy.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p>	11/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>quarters of the mixture and then turned his head and mouth away when the nurse attempted to get him to drink the remaining mixture. The nurse then indicated she would wait to give the remaining mixture when he started to eat his dinner. At 6:02 PM when client #89 went into the dining room, nurse #39 attempted to administer the remaining mixture to client #89. Client #89 again moved his head and mouth away. Nurse #39 added chocolate milk to the mixture and administered the medications.</p> <p>A review of the facility's Medication Administration General Guidelines, dated 09/08, was reviewed on 9/27/12 at 10:44 AM. The policy indicated, in part, "Medications should not be given at mealtimes or in the dining room unless specifically ordered with meal."</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/27/12 at 9:47 AM. The DON indicated the nurse should have attempted to re-administer the medications prior to client #89 going into the dining room for dinner.</p> <p>2) An observation was conducted on the second floor of the facility on 9/25/12 from 4:24 PM to 6:08 PM. On 9/25/12 at 4:30 PM, nurse #39 prepared client #89's medications. Client #89's 9/25/12 8:00</p>		<p>III 1. Client's will have their medications given per amended policy for Medication Administration which states <i>Medication can be administered in the Dining Room before residents actively begins to eat their meal or after completion of their meal. Medications should NOT be given while the client is eating their meal unless ordered by Physician medications is to be given with meal. Medication may also be given in the hallway, nurses station, resident's room or any other designation that is requested by the resident.</i></p> <p>Nursing has been educated on this revision to the Medication Administration Policy.</p> <p>2. Nursing has been re-educated on the procedure to check their work at the end of each shift with assurance that disciplinary action will result in audits that reveal holes in their MARs.</p> <p>3. Nurses have been re-educated on the drug destruction policy.</p> <p>IV 1. Medication observations are completed by DCE, Evening shift nurse supervisor and Designees that include medications administered around meal times.</p> <p>2. Mars are audited weekly by</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>AM (Sulfamethoxazole, Betamethasone Dipropionate, Claritin, Calcium Carb, Colace, Simethicone, Divalproex, and Tegretol) and noon medications (Divalproex and Tegretol) on the MAR were not initialed as administered; the MAR was blank. At 4:52 PM, nurse #39 prepared client #8's medications. Client #8's 8:00 AM (Bacitracin, Benztropine Mesylate, Colace, Zyprexa, Trileptal, and 2.0 calorie supplement) and noon medications (Bacitracin, ice cream, and 2.0 calorie supplement) on 9/25/12 were not initialed as administered on the MAR. At 5:03 PM, nurse #39 prepared client #88's medications. Client #88's 8:00 AM (Cogentin, Lasix, Potassium Chloride, and Depakote Sprinkles) and noon (Depakote Sprinkles) medications were not initialed as administered on the MAR. At 5:13 PM, nurse #39 prepared client #9's medications. Client #9's 8:00 AM (2 cal supplement, Folbee Plus, Potassium Chloride, Lasix, Calcarb, Depakote ER, Trileptal and Nystatin) and noon (Trileptal) medications were not initialed as administered on the MAR. Client #73's medications for 9/25/12 at 8:00 AM (Acetaminophen, Celexa, Cozaar, Lisinopril, cranberry juice, Desonide, Metoprolol Tartrate, Artificial tears, and aspirin) and noon (artificial tears) medications were not initialed as administered on the MAR.</p>		<p>Nursing Management and Designees from North Willow management team with issues followed up by the nursing management team. Nurses check their work at the end of each shift.</p> <p>3. During Medication Administration observations, drug destruction, when applicable will be observed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A review of the facility's Medication Administration General Guidelines, dated 09/08, was reviewed on 9/27/12 at 10:44 AM. The policy indicated, in part, "The individual who administers the medication dose, records the administration on the resident's MAR following the medications being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications."</p> <p>An interview with nurse #39 was conducted on 9/25/12 at 4:58 PM. Nurse #39 indicated nurse #40 was responsible for the administration of the 8:00 AM and noon medications on 9/25/12. Nurse #39 indicated nurse #40 failed to initial the MAR. Nurse #39 indicated this was a medication error.</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/25/12 at 5:11 PM. The DON indicated it was a documentation error. The DON contacted the nurse responsible for administering the 8:00 AM and noon medications (nurse #40) and nurse #40 informed the DON she did administer the medications. The DON indicated nurse #40 was going to come back to the facility to initial the MAR. A second interview with the DON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 conducted on 9/27/12 at 9:47 AM. The DON indicated nurse #40 did not follow the policy; nurse #40 did not sign after administering the medications.</p> <p>An interview with nurse #40 was conducted on 9/25/12 at 6:08 PM when she returned to work to initial the MAR. Nurse #40 indicated she did not initial the MAR due to a fire drill being conducted at the facility during her shift.</p> <p>A review of the facility's fire drill, dated 9/25/12, was conducted on 9/27/12 at 10:59 AM. The drill form indicated the drill was conducted from 10:30 AM to 10:50 AM.</p> <p>3. During medication administration observations on 09/26/2012 at 4:45 p.m., LPN #11 prepared Calcitrol 0.25 mcg (micrograms) tablet for client #17. LPN #11 took the medication to the client in the first floor dining room. Client #17 was eating dinner. LPN #11 returned to the medication cart with the medication and stated, "I can't give him his med (medication) because he is eating." LPN #11 threw the tablet into the trash receptacle on the side of the medication cart.</p> <p>During medication administration observations on 09/25/2012 at 6:00 p.m.,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>LPN #11 prepared the following medications for client #24: Miralax 3350 (for constipation) 1/2 capful in 8 ounces of water, 2.0 cal (nutritional supplement) 120 ml (milliliters), Prilosec (to treat gastric reflux) 20 mg (milligrams) tablet, Calcium 600 mg with Vitamin D 400 IU (international units) tablet, Colace (stool softer)100 mg tablet, Famotidine (for gastric reflux or ulcers) 20 mg tablet, Tegretol (for seizures) 200 mg tablet, Depakote (for seizures) 250 mg - 4 capsules, and Vimpat (for seizures) 200 mg tablet. LPN #11 took the medications to client #24's room. Client #24 drank all of the 2.0 cal. He refused to drink the water with the Miralax mixed in it and spit all medication tablets/capsules out of his mouth and into his lap and on the floor. LPN #11 picked the medications and verified all medications had been retrieved. LPN #11 stated, "He's just doing this because you're here." The medications were flushed down the toilet. No other nurses were present for the destruction.</p> <p>An April 1, 2003 "Medication Destruction Policy" was reviewed on 09/27/2012 at 9:00 a.m. The policy indicated, "...all medications are disposed of in an acceptable manner...Medication destruction occurs only in the presence of two licensed nurses or one licensed nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 a pharmacist...Wasted individual doses should be recorded...on a house document...."</p> <p>During an interview on 09/26/2012 at 4:45 p.m., the Director of Education (DoE) indicated LPN #11 should not have disposed of the medication in the trash receptacle on the medication cart. The DoE indicated the medication should have been flushed down the toilet.</p> <p>During an interview on 09/26/2012 at 6:00 p.m., LPN #11 indicated refused/contaminated medications should be flushed down the toilet.</p> <p>During an interview on 09/27/2012 at 11:00 a.m., The Director of Nursing (DoN) stated, "Individual medications are flushed down the toilet. Large volumes of medications are returned to the pharmacy for medication disposal." The DoN indicated LPN #11 violated facility policy by not completing a medication destruction form listing clients #17's and #24's medications that were flushed.</p> <p>3.1-17(a) 3.1-25(b)(3) 3.1-25(o)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 1 of 43 doses of medication observed to be administered, the facility failed to ensure medications were administered without error for client #9.</p> <p>Findings include:</p> <p>On 9/25/12 at 5:13 PM, nurse #39 prepared client #9's medications (Calcium for a nutritional supplement, Divalproex 500 milligrams for seizures and Oxcarbazepine for seizures). Nurse #39 closed the medication cart drawer and the medication administration record (MAR) and turned to give client #9 his medications. The surveyor informed nurse #39 she did not prepare all client #9's medications listed on the MAR (dated 9/1/12 - 9/30/12). The nurse had not prepared client #9's Divalproex Sodium 250 milligram dose (to be given with a 500 milligram tab). Nurse #39 then reopened the MAR, checked it, reopened the med cart drawer, added a 250 milligram tab of Divalproex tab to the med cup and then administered client</p>	W0369	<p>W369</p> <p>I Client 17 and 24's nurse, #11 has been retrained on the drug destruction policy.</p> <p>II All residents of North Willow have the potential to be harmed by the deficient practice.</p> <p>III Nurses have been re-educated on the drug destruction policy.</p> <p>IV During Medication Administration observations, drug destruction, when applicable will be observed.</p> <p>All of plan to be completed by November 1, 2012.</p> <p>Attachments include items for: W136 W154 W227 W289 W331</p>	11/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 his medications.</p> <p>An interview with nurse #39 was conducted on 9/25/12 at 5:20 PM. Nurse #39 indicated she missed preparing the Divalproex 250 milligram tab. Nurse #39 stated she was "nervous."</p> <p>An interview with the Director of Nursing (DON) was conducted on 9/27/12 at 9:47 AM. The DON indicated nurse #39 was new to the floor. The DON indicated the nurse should have double-checked the medications she prepared prior to starting to administer them.</p> <p>This deficiency was cited on 8/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				