

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for the investigation of complaint #IN00141083.</p> <p>Complaint #IN00141083: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 1/16/14, 1/17/14 and 1/21/14</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 1/23/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, record review and</p>	W000137	W1371 Client C has a plan	02/20/2014

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

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

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	<p>interview for 1 of 13 sampled clients (C), the facility failed to ensure client C had access to his personal clothing.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 1/17/14 from 10:00 AM through 11:45 AM. Client C's bedroom closet was observed at 11:33 AM. Client C's bedroom closet had a locked padlock on the door.</p> <p>Client C's record was reviewed on 1/17/14 at 12:33 PM. Client C's ISP (Individual Support Plan) dated 4/29/13 did not indicate client C's bedroom closet should be locked.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/17/14 at 11:35 AM. QIDP #1 indicated client C's bedroom closet door was locked. QIDP #1 indicated client C's bedroom closet contained his personal clothing. QIDP #1 stated, "[Client C] just moved to this unit. [Client C]'s new roommate likes to steal his things." QIDP #1 indicated client C did not have a key to his bedroom closet. QIDP #1 indicated the locking of client C's bedroom closet was not included in his BSP (Behavior Support Plan).</p>		<p>approved by HRC that approves locking his clothing that includes a goal to open the lock. The room change form has been updated to include addressing client specific needs and restrictions with Human Rights Committee approval when required. Client C's QMRP, Social Worker and staff trained on the form and process. Competency training completed with staff on restriction of resident rights like use of appropriate personal possessions and clothing. II Any resident who resides at North Willow might be affected by the issue sited in this survey. III Program Directors/QMRPs have audited all residents to assure Human Rights Committee approval is in place for any restriction including clothing and personal possessions. Any restriction includes programming that addresses the restriction. The room change form has been updated to include addressing client specific needs and restrictions with Human Rights Committee approval when required. QMRPs and Social Workers and staff trained on the form and process. Competency training completed with staff on restriction of resident rights like use of appropriate personal possessions and clothing. Program Director is responsible to assure that a goal is in place and Human Rights Committee approval is obtained</p>		

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W000262	<p>3.1-9(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 1 of 13 sampled clients (C) with restrictive programs, the facility's HRC (Human Rights Committee) failed to review, monitor and approve the locking of client C's bedroom closet.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 1/17/14 from 10:00 AM through 11:45 AM. Client C's bedroom closet was observed at 11:33 AM. Client C's bedroom closet had a locked padlock on the door.</p>	W000262	<p>when needed. IV Room changes now include review of the Executive Director. An audit is completed at least monthly by Program Director/Designee to assure restrictions of residents including personl items is current and has been approved by Human Rights Committee. Quality Assurance team reviews the Program Director auditing process for completion monthly. Corrections to be completed by 2-20-2014.</p> <p>W262 I Client C has a plan approved by HRC that approves locking his clothing that includes a goal to open the lock. The room change form has been updated to include addressing client specific needs and restrictions with Human Rights Committee approval when required. Client C's QMRP, Social Worker and staff trained on the form and process. Competency training completed with staff on restriction of resident rights like use of appropriate persona possessions and clothing. II Any resident who resides at North Willow might be affected by the issue sited in this survey. III Program Directors/QMRPs have audited all</p>	02/20/2014	

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	<p>Client C's record was reviewed on 1/17/14 at 12:33 PM. Client C's ISP (Individual Support Plan) dated 4/29/13 did not indicate client C's bedroom closet should be locked. Client C's record did not indicate documentation of the facility's HRC review, monitoring or approval of locking client C's bedroom closet.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/17/14 at 11:35 AM. QIDP #1 indicated client C's bedroom closet door was locked. QIDP #1 indicated client C's bedroom closet contained his personal clothing. QIDP #1 stated, "[Client C] just moved to this unit. [Client C]'s new roommate likes to steal his things." QIDP #1 indicated client C did not have a key to his bedroom closet. QIDP #1 indicated the locking of client C's bedroom closet was not included in his BSP (Behavior Support Plan) and was not HRC (Human Rights Committee) approved.</p>		<p>residents to assure Human Rights Committee approval is in place for any restriction including clothing and personal possessions. Any restriction includes programming that addresses the restriction. The room change form has been updated to include addressing client specific needs and restrictions with Human Rights Committee approval when required. QMRPs and Social Workers and staff trained on the form and process. Competency training completed with staff on restriction of resident rights like use of appropriate personal possessions and clothing. Program Director is responsible to assure that a goal is in place and Human Rights Committee approval is obtained when needed. IV Room changes now include review of the Executive Director. An audit is completed at least monthly by Program Director/Designee to assure restrictions of residents including person items is current and has been approved by Human Rights Committee. Quality Assurance team reviews the Program Director auditing process for completion monthly. Corrections to be completed by 2-20-2014.</p>		