STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/29/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC 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	This visit was for a post-certification revisit (PCR) survey to the investigation of complaints #IN00108475 and #IN00107765 completed on 5/23/12. This visit resulted in an Immediate Jeopardy. This visit was in conjunction with the investigation of complaint #IN00109013. This visit was in conjunction with a PCR to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12. This visit was in conjunction with a PCR to the investigation of complaint #IN00103890 completed on 3/26/12. This visit was in conjunction with a PCR to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12. Unrelated deficiencies-Corrected. Dates of Survey: 6/25, 6/26, 6/27, 6/28 and 6/29/12 Facility Number: 000622 Provider Number: 15G079 Aim Number: 100272170	W0000	**All corrective action completed by 7-29-12** **DISCLAIMER STATEMENT** - **Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law.** **"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Surveyors: Paula Chika, Medical Surveyor III-Team Leader Keith Briner, Medical Surveyor III Brenda Nunan RN, Public Health Nurse Surveyor III This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality Review completed 7/10/12 by Ruth Shackelford, Medical Surveyor III.			

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 14 allegations of abuse/neglect and/or injuries of unknown origin reviewed (client #11), the facility failed to complete/report the results of an investigation of a death within 5 business days. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 6/25/12 at 1:54 PM. The facility's 6/14/12 reportable incident report indicated "Client (client #11) became unresponsive. CRP (sic) cardiopulmonary resuscitation) administered. 911 called. Client was taken to the emergency room." The facility's 6/17/12 reportable incident report indicated "Resident (client #11) complained of abdominal discomfort at approx. (approximately) 11:00 AM (sic) Nursing assessed, and resident suddenly became unresponsive with no palpable pulse. Nursing initiated CPR and 911 was phoned. EMS (Emergency	W0156	**W156 Staff Treatment of Clients** **The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.** **I Corrective Action for Cited Clients:** Resident 11 is deceased. Client Advocate Department are now on duty regularly from 8:30 am to 8 pm Monday through Friday. Nursing informs Client Advocates during working hours of any reportable incident to assure timely reporting. **II Other Clients Potentially at Risk:** **All residents of North Willow are potentially at risk for this incorrect practice.** **III Corrective Measures or Systemic Changes:** Client Advocate Department are now on duty regularly from 8:30 am to 8 pm Monday through Friday. Nursing informs Client Advocates during working hours	07/29/2012

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	Management Services) arrived and continued CPR, and transported to hospital at 11:15 AM. Resident expired at hospital at 5:46 PM on 6-17-12. Hospital reports cardiac arrest, and 'abdominal catastrophy'." The 6/17/12 reportable incident report indicated client #11's death was a "Sudden death." The reportable incident report indicated the facility was conducting an investigation. Interview with the Director of Nursing (DON) on 6/27/12 at 10:00 AM indicated the facility was still in the process of investigating client #11's death. The DON stated "Too many people there. Work in progress." Interview with Program Director #3 on 6/27/12 at 3:32 PM indicated she had not completed the investigation in regard to client #11's death. Administrative staff #3 indicated she still had some people to interview. This federal tag relates to complaints #IN00108475 and #IN00017965. This deficiency was cited on 5/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(e)		of any reportable incident to assure timely reporting. Client Advocates are sending report via e-mail to ED of completed report. **IV Monitoring Corrective Measures:** Executive Director to track reportable events to assure follow up is received in the 5 day timeline. E-mail report from Client Advocates confirms report is complete. -	

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