

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2012
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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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W0000	<p>This visit was for the post-certification revisit (PCR) survey to the PCR completed on 6/29/12 to the investigation of complaints #IN00108475 and #IN00107965 completed on 5/23/12 which resulted in an Immediate Jeopardy.</p> <p>This visit was in conjunction with a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00113231.</p> <p>This visit was in conjunction with a PCR to the investigation of complaint #IN00109013 completed on 6/29/12.</p> <p>This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12.</p> <p>This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaint #IN00103890 completed on 3/26/12.</p> <p>This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12.</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.

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	<p>Complaint #IN00108475-Not Corrected.</p> <p>Complaint #IN000107965-Not Corrected.</p> <p>Dates of Survey: 8/6, 8/7, 8/8, 8/9, 8/10 and 8/17/12</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 III (8/6/12 to 8/9/12) Dotty Walton, Medical Surveyor III (8/6/12 to 8/9/12) Mark Ficklin, Medical Surveyor III (8/6/12 to 8/9/12) Joann Scott, Medical Surveyor III (8/6/12 to 8/9/12) Steven Schwing, Medical Surveyor III (8/6/12 to 8/9/12) Keith Briner, Medical Surveyor III (8/6/12 to 8/9/12)</p> <p>This deficiency also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 8/23/12 by Ruth Shackelford, Medical Surveyor III.</p>				

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W0156	<p>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 3 of 16 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to ensure all results/investigations were completed within 5 business days with the results reported to the administrator for clients #9, #128 and #130.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 8/6/12 at 3:42 PM. The facility's 7/28/12 reportable incident report indicated "Client (client #9) walking down hallway toward dining room and suddenly showed signs of discomfort in her left foot. Client sat down on floor and pointed to her left foot and would not stand. A portable X-ray was taken on 7/28/12 of Lt (left) foot and ankle. Results showed no fracture or dislocation. on (sic) 7/29/12 client continues to show S/S (signs/symptoms) of discomfort to left foot and leg and resistance to bear weight on leg. Client PRN (as needed) Tylenol for discomfort</p>	W0156	<p>W156 I The agency has in place policies to report the results of investigations to the administrator or designee within 5 working days. Investigations for clients #9 (7/28/12 fracture), #80 (8/1/12 injury of unknown origin), and #128 & 130 (client to client) have been completed. Client advocates will be retrained on the requirement that investigations be completed within 5 working days. II All residents of North Willow have the potential to be harmed by the deficient practice. III To help prevent reoccurrence of the issue, the client advocates will review daily the outstanding reportable incidents, noting due dates for completion of investigations and submission of follow-up BDDS incident report if required. Documentation of these meetings will be maintained in the client advocates' office. The Executive Director will be notified of any problems arising that might prevent the completion of an investigation to determine how to proceed. 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,</p>	09/16/2012			

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	<p>and sent to [name of hospital] for further evaluation."</p> <p>The facility's 7/30/12 follow-up report indicated "This is a follow up to the ER (emergency room) visit on 7/29/12 to report a fracture. [Client #9]...returned from [name of hospital] 7/29/12 with a diagnosis of fracture to left ankle...[Client #9] was noted to have maladaptive behaviors on 7/27/12. [Client #9] is non-verbal and ambulatory. She has a diagnosis including Osteoporosis, Epilepsy, and Unspecified Thrombocytopenia. Investigation in progress...." Review of the facility's 7/28/12 reportable incident report and 7/30/12 follow up report, indicated the facility was still conducting an investigation in regard to the client's fracture of unknown origin as of 8/9/12.</p> <p>Interview with administrative staff #3, #4, and #5 on 8/9/12 at 11:35 AM indicated the facility was still conducting an investigation in regard to the client's fracture. Administrative staff #3 stated client #9's fracture was most likely the result of the client's "behavior of getting on the floor and stomps her feet."</p> <p>2. The facility BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed</p>		<p>investigation summary reports will be emailed to the Executive Director.</p>				

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	<p>on 8/6/12 at 6:20 PM. The review indicated the following:</p> <p>-BDDS report dated 8/2/12 indicated on 8/1/12 client #80 was being showered when staff identified an abrasion on his upper left thigh. The BDDS report indicated the origin of the injury was not known. The BDDS report included a Verification of Investigation (VI) form dated 8/2/12. The VI did not indicate the outcome of the investigation regarding the source of client #80's abrasion on his upper left thigh.</p> <p>-BDDS report dated 8/2/12 indicated on 8/1/12 client #128 hit his peer client #130 twice. The review did not indicate an investigation regarding this incident of client to client aggression.</p> <p>Interview with Administrative Staff (AS) #2 on 8/9/12 at 12:30 PM indicated the results of investigations should be completed within five business days of the incident.</p> <p>This federal tag relates to complaints #IN00108475 and #IN00107965.</p> <p>This deficiency was cited on 6/29/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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	3.1-28(e)			