

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 11/09/2011
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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, IN46260
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W0000	<p>This visit was for an investigation of complaints #IN00098167 and #IN00098684.</p> <p>Complaint #IN00098167: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W104 and W149.</p> <p>Complaint #IN00098684: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W104, W137, W149, W154 and W227.</p> <p>Dates of Survey: 10/24, 10/25, 11/1 and 11/9/11</p> <p>Facility Number: 000622 Provider Number: 15G079 Aim Number: 100272170</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 11/16/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>DISCLAIMER STATEMENT</p> <p>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.</p> <p>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."</p>	
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and</p>	W0104	W104	12/09/2011

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>record review for 2 of 4 sampled clients (A and D), the governing body failed to exercise general policy, budget and operating direction over the facility to review/develop a plan of action and/or to put a system in place which would prevent clients from eloping from the facility without staff's knowledge.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/25/11 at 11:25 AM. The facility's reportable incident reports indicated the following:</p> <p>-10/31/11 reportable incident report indicated on 10/30/11, "...[Client A] left the third floor coming down the west stairwell. He exited the west hall door on the first floor setting off the alarm. The staff immediately reacted and went out the door after [client A]. The staff were able to talk to [client A] and help him calm down and return to the facility." The 10/31/11 incident report indicated client A was upset over the dining room menu and appeared to calm down but then "copied the behavior" of another client and left the third floor as staff were dealing with another client who left and went to the first floor.</p>		<p>I Corrective Action for Cited Clients: Client A's plan has been reviewed and a hall monitor is in place on the third floor until an electronic system can be put into place. Client A's plan has been updated and staff have been trained. Client D's plan has been updated and all core staff have been trained.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: Each resident has been assessed as to their elopement risk and need of service by an electronic system. The Client Advocates have been trained by a Golden Living Corporate employee. For those deemed to be at risk for elopement and in need of it, an electronic system has been proposed via a Capital Expense Request to be installed at North Willow which includes alarms, and locks along with personal monitors for those</p>	

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	<p>-10/6/11 reportable incident report indicated "Resident (client D) eloped from the facility. Amber alert called...AVS (workshop) supervisor, ED (Executive Director), Program Director and CNA located residentialmost (sic) immediately behind facility. Resident returned with staff willingly to facility. Body assessment completed with no injury noted. Resident was placed on 15 min. (minute) checks. Building hall monitor initiated to watch first floor exits. Team will meet further to discuss plan."</p> <p>The facility's 10/12/11 follow-up report indicated "[Client D] left the building without permission. She has been sitting at the front desk talking to the receptionist which she frequently does. When staff went to look for her for lunch and she was not found, an amber alert was initiated. [Client D] was found by staff 0.2 miles from facility...Staff report that resident was visiting receptionist sitting at the front desk. Staff report that she seemed fine without signs of agitation. Nursing reports [client D] had taken her meds and was seen walking into the dining area approximately 10 minutes prior to elopement. Program Director reports that [client D] had been attempting to talk to ED and that ED had been busy in meetings during the morning. PD (Program Director) reports that [client D]</p>		<p>assessed to need them. The quote for this system is available upon request.</p> <p>IV Monitoring Corrective Measures: Upon installation of the electronic monitoring system, staff will be trained in its use and QMRP staff trained as to the parameters that require its need. A policy has been drafted which addresses elopement. Will be completed by 12-9-11.</p>		

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	<p>was unhappy about having to wait to talk to ED. Per investigation, [client D] spoke with ED at approximately 11:33 AM, and staff began looking for her at 11:35 AM. Resident arrived back at the facility at 11:53 AM." The 10/12/11 follow-up report indicated client D was placed on 15 minute checks with a monitor at the front door for 72 hours. The follow-up report indicated "...The following are recommendations agreed upon by the team:</p> <p>Per [client D's] Behavior Support Plan, she is to make an appointment to speak to the administrator. [Client D] will be encouraged to remain in her assigned area and participate in group activities. Her BSP (Behavior Support Plan) will be revised to include reinforcers she can earn for participating in active treatment and remaining in her assigned area. If [client D] does sit at the front desk conversing with the receptionist, she will be on 5 minute checks. All her staff will be trained on changes in her BSP."</p> <p>A 10/6/11 witness statement by the receptionist indicated an "amber alert" (code to tell staff a client could not be located in the building) was called over the intercom. The witness statement indicated another staff person who was on their way home called back to the facility to tell the receptionist she saw one of the</p>			

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	<p>clients.</p> <p>-8/24/11 "[Client A] eloped from the facility. Staff were able to get the client to come back into the facility."</p> <p>The facility's 8/26/11 follow-up report indicated "On 8-25-11 a staff member from the second floor reported that a client on the third floor had eloped on 8-24-11. She reported that she had clocked out and was leaving. As she was walking down the ramp toward the parking lot she saw a third floor client outside of the building without any staff. She then returned inside the building and alerted a staff member to call a 'code green' for a third floor client. The QMRP, the CNA, and this second floor QMRP were suspended pending investigation for not reporting an elopement immediately. A third floor monitor was initiated to watch the exits. This person will alert other staff if a client goes out any of the exits. Then alerted staff are to intervene accordingly. [Client A] was placed on 15 minute checks." The 8/26/11 follow-up report indicated client A was upset and left his third floor unit. The follow-up report indicated "...His QMRP immediately alerted a male staff member from the south hall to assist her. The staff went down the west hall stairwell to the first floor west hall. As they were coming</p>			

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	<p>down the hallway they overheard another staff member calling for someone to call for help [client A] is outside of the building heading toward 86th street. That staff member then immediately went out the north door to intervene with [client A]. The third floor staff went out the south door to intervene with [client A]. There the staff was able to talk with [client A] and problem solve. He was heading to [name of fast food restaurant] but did not have any money...The second floor QMRP stated that she did not report the alleged elopement because [client A's] QMRP was on the scene and she anticipated that she would. This staff (administrative staff #4) viewed this is an elopement because she did not realize that the third floor staff were in pursuit and knew of [client A's] whereabouts. Conclusion: The investigation revealed this was not an elopement. This is why the third floor QMRP and CNA did not report it. The third floor QMRP did however report it as an AWOL,...."</p> <p>During the 10/25/11 observation period between 6:30 AM and 10:00 AM, at the facility, there was no door monitor at the front door of the facility at 6:30 AM. At 6:47 AM, a staff person was sitting at the front desk area monitoring the doors. Interview with CNA #6 on 10/25/11 at 6:47 AM indicated she was working as a</p>				

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	<p>door/hall monitor. During the 10/25/11 observation period, client D utilized a roller walker when ambulating. At 7:04 AM, on the third floor, no hall monitor was present. While at the facility doing record reviews on 11/1/11 at 10:20 AM a door monitor was located in the intersection of the hallways on the third floor.</p> <p>Client D's record was reviewed on 11/1/11 at 9:14 AM. Client D's 10/6/11 BIR indicated "Clt (client) had been trying to talk w/ (with) ED throughout the morning hours & was upset that ED was busy in mtgs (meetings). When staff were unable to locate [client D] amber alert was called. Staff were searching the neighborhood immediately behind the facility...[Client D] indicated she just wanted some fresh air...door monitor was implemented & nursing completed an assessment on her w/ 0 (zero) issues found."</p> <p>Client D's Behavior Incident Reports (BIRs) indicated the following:</p> <p>-10/14/11 "Resident walked out of building without telling staff but staff member was behind her at all times...." The BIR indicated client D "...took a walk in a nearby neighborhood...."</p>						

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	<p>-8/4/11 client D went outside with staff following her as the client was mad and client D was going to see her sister. The BIR indicated client D refused to use her walker and wanted to walk without it.</p> <p>Client A's record was reviewed on 11/1/11 at 1:21 PM. Client A's BIRs indicated the following:</p> <p>-10/6/11 client A went down west hall and did not respond to redirection, exited the building and crossed the street.</p> <p>-9/21/11 client A left his unit and went down 3 west hall to the stairwell.</p> <p>-9/15/11 client A "walked down west hall and went down to first floor exited out the fire door...."</p> <p>-9/7/11 went AWOL (absence without leave) down the 3 north hall stairs.</p> <p>-8/28/11 client A got upset and went AWOL out of the building.</p> <p>-8/27/11 "[Client A] walked down to first floor and eventually out of the building. He was followed by two staff...at an acceptable distance. They managed to redirect him back to the building."</p> <p>-8/8/11 client A went "Awoling over</p>						

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	<p>food." The BIR indicated client A left the third floor, went outside the building, got to 86th street and ran across the parking lot to another parking lot and then came back inside the building.</p> <p>-8/6/11 client A ran out of the building to a nearby road with staff running behind him.</p> <p>Interview with CNA #8 on 10/25/11 at 6:55 PM indicated client A would elope/go AWOL from the facility. CNA #8 indicated client A would get outside the building and cross the street. CNA #8 indicated staff would be with the client and/or behind him when he attempted to leave. CNA #8 indicated client A had also gotten out of the building without staff's knowledge in the past.</p> <p>Interview with administrative staff #6 and Qualified Mental Retardation Professional (QMRP) #2 on 11/1/11 at 11:05 AM indicated client D had a history of eloping from the facility and/or attempting to elope. Administrative staff #6 indicated client D liked to sit up front in the office area which was near the main doors. Administrative staff #6 indicated client D would attempt to elope when the client was upset. Administrative staff #6 indicated client D's 8/30/11 interdisciplinary team note indicated staff</p>				

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	were to keep the client in line of sight when she was agitated to prevent the client from eloping. Administrative staff #6 indicated client D had left the front desk area and walked back toward the dining room area. Administrative staff #6 indicated client D was wanting to speak with the ED and became upset when she could not speak with her. Administrative staff #6 indicated client D then eloped from the facility via the main doors of the facility. Administrative staff #6 stated there was a "break down in communication" as staff was not aware client D was mad at the ED on 10/6/11. Administrative staff #6 and QMRP #2 stated client D was found in the neighborhood behind the facility which was "approximately 2 tenths of a mile from the facility." Administrative staff #6 indicated she thought it would take client D 3 to 4 minutes to walk to the point where she was found with a walker. Administrative staff #6 and QMRP #2 indicated the client had walked around the curb. Administrative staff #6 and QMRP #2 indicated there had not been any other elopements since the 10/6/11 incident. Administrative staff #6 indicated a door monitor was only being utilized on 10/25/11, as the staff person required light duty and not due to an incident of elopement. When asked how the facility was addressing the incidents of elopement				

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	<p>without staff's knowledge, administrative staff #6 stated a hall/door monitor was not a "standing routine to prevent elopement."</p> <p>Interview with administrative staff #7 and QMRP #1 on 11/1/11 at 12:45 PM indicated client A went AWOL/eloped from the facility on 10/30/11. Administrative staff #7 and QMRP #1 indicated client A eloped from the facility without staff's knowledge when facility staff were busy with other clients. QMRP #1 indicated staff did not see the client until he got out of the west hallway door and alarm sounded. QMRP #1 and administrative staff #7 indicated client A got down to the street to another nursing home type facility before staff were able to get the client redirected back to the building. QMRP #1 and administrative staff #7 indicated a hall monitor was put in place after client A eloped from the building on 10/30/11. Administrative staff #7 stated the hall monitor was needed and should stay in place to prevent clients from eloping without staffs' knowledge.</p> <p>Interview with administrative staff #1, #2 and #3 on 11/1/11 at 5:10 PM indicated clients A and D had a history of eloping from the building with and without staffs' knowledge. Administrative staff #1 indicated client D was moved to the first</p>				

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	<p>floor due to going AWOL from the third floor using the stairwell with her ambulation/gait issues. Administrative staff #1 indicated client D was found in the neighborhood behind the facility. Administrative staff #1 indicated client D eloped out of the main front door. Administrative staff #1 indicated client A left the building through the west hall door which was alarmed. Administrative staff #1 stated staff heard the alarm and went out "immediately" behind him. Administrative staff #2 indicated client A would elope using the west hall door exit. Administrative staff #1 and #2 indicated a door monitor, on the first floor, would not see client A exit from the stairway as there was a closed door to the stairwell. Administrative staff #1, #2 and #3 indicated a third floor hall monitor had been put in place since client A eloped from the building to prevent the client from eloping without staff's knowledge. Administrative staff #1 indicated the third floor hall monitor would be in effect for 72 hours per the facility's policy and then removed. Administrative staff #1 and #3 indicated a hall monitor had been placed on the third floor in the past for longer periods of time. Administrative staff #1 stated "We had a hall monitor on the third floor for several weeks, indefinite. Things calmed down and clients were doing very well. It was removed."</p>				

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W0137	<p>Administrative staff #1 indicated client D was agitated when she eloped on 10/6/11. When asked how the facility was addressing/preventing clients from eloping from the building without staff's knowledge, administrative staff #1, #2 and #3 indicated they were in the process of discussing the issue to put additional measures in place.</p> <p>This federal tag relates to complaints #IN00098167 and #IN00098684.</p> <p>3.1-13(a) 3.1-13(r)</p> <p>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.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (C), the facility to ensure the client had an adequate supply of underwear, pajamas and/or proper fitting clothes to wear.</p> <p>Findings include:</p> <p>During the 10/25/11 observation period between 6:30 AM and 10:00 AM, at the facility at 9:40 AM, client C was walking down 2 North hall. Client C's pants fell down to his ankle. Client C was naked from the waist down. Client C did not</p>	W0137	<p>W137 1 Corrective Action for Cited Clients:</p> <p>For Client C his clothing has been audited by his QMRP and Social Worker and appropriate purchases have been made.</p> <p>A weekly audit is completed of client C's clothing and observation is done daily for 4 weeks, then weekly thereafter to assure underwear and pajamas is present and encouraged to be worn.</p>	12/09/2011

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	<p>have any underwear on. Client C reached down, pulled his pants up and held them at the waist line and walked into the classroom.</p> <p>Client C's wardrobe/closet in his room was checked on 10/25/11 at 9:44 AM with the social service coordinator. Client C's wardrobe/dresser indicated client C did not have any underwear in his wardrobe/dresser. At 9:50 AM, in the laundry room, the laundry attendant was able to locate 2 pairs of underwear for client C. Interview with the laundry room attendant on 10/25/11 at 9:50 AM indicated she was not able to locate any additional underwear for the client, and she would take the 2 pairs of underwear she found to client C's bedroom.</p> <p>Interview with CNA #3 on 10/25/11 at 6:19 PM indicated she thought client C had some underwear in his closet. CNA #3 indicated client C did not have any pajamas to sleep in as the client would have to sleep in his clothes or sweat pants.</p> <p>This federal tag relates to complaint #IN00098684.</p> <p>3.1-9(a)</p>		<p>If he refuses to wear it, a BIR is written.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: The Social Workers have been retrained with emphasis on 3rd floor as to shopping, items to procure and how to determine sizes. An audit of pajamas has been completed with an IDT which indicates the type of sleep attire preferred by each resident. Social Worker will meet with staff and residents to address appropriate clothing weekly for 4 weeks and then every other week for 4 weeks and then monthly thereafter. Staff have been educated to document when there are issues involving refusal to wear items that are appropriate and fit and to report when quantities are low. If needed, the client's IDT will formulate a plan or otherwise address clothing issues caused by resident</p>		

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W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.		<p>behavior or preference. Also any issue of lateness or other laundry issues will be addressed including grievances or other measures as deemed necessary by administration when warranted. Additionally a Resident Appearance Checklist has been posted on each unit and referred to as a reminder of appropriate appearance of residents and when education and simple reminders fail to elicit appropriate staff action it will be addressed with formal documentation including disciplinary actions. QMRP will audit appropriate dress and cleanliness as part of active treatment audit which is done 3 times per week.</p> <p>IV Monitoring Corrective Measures: Program Directors will review clothing needs with Social Workers at least weekly for 4 weeks and then monthly thereafter. To be completed by 12-9-11.</p>	

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	<p>Based on observation, interview and record review for 2 of 4 sampled clients (B and D), the facility failed to implement its policy and procedures to prevent neglect of clients in regard to an elopement incident with client D and in regard to client B's fractures.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/25/11 at 11:25 AM. The facility's 9/30/11 reportable incident report indicated "Swelling noted in RT (right)/leg unable to bear wt. (weight). MD (medical doctor) notified. Sent to ER via ambulance. The 10/7/11 follow-up report indicated "[Client B] presented with edema to her lower extremities. The right leg was more swollen then the left. [Client B] also presented with guarding of her right leg not wanting to bear weight. X-rays were done at the hospital. Results reflected fracture of distal tibia and fibula (closer to the ankle)...The night nurse reported that she went into [client B's] room in the morning to administer medication to [client B's] roommate. The nurse reports that [client B] was awake already standing up beside her bed with her walker beside of her. [Client B] began to ask the nurse for pens (usual behavior) through her sign language and</p>	W0149	<p>W149</p> <p>I Corrective Action for Cited Clients:</p> <p>Client B's IDT has developed a plan related to her sitting on the floor as a behavior. The investigation of Client B's fracture was reopened and reinvestigated with follow up completed as appropriate. The other fracture has been investigated. The 10-3-11 incident of unknown bruising has been reopened and further investigation completed. Client D's behavior support plan has been updated to include specific method of monitoring and supervision to prevent elopement. Training on her plan has been completed with core staff.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: QMRPs were trained that after an IDT has identified follow up action/training, this action/training must be</p>	12/09/2011	

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	<p>gesturing. The nurse reports that when she told [client B] she did not have a pen for that [client B] sat herself down to the floor. The nurse did not notice if [client B] sat on her foot or not. She continued to give the medication to the roommate. After she had completed administering the medication she then went to [client B] and instructed her to get up. The nurse offered to help her up off the floor. [Client B] normally can get up all by herself. The nurse stated she thought [client B] was having a behavior. [Client B] acted as if she could not get up. The nurse went and got staff to help her with [client B]. The nurse and the CNA (certified nurse aide) assisted [client B] up to her bed. The right ankle also had discoloration around it. [Client B] was sent to the hospital for evaluation and treatment.</p> <p>The staff reported that [client B] has recently moved to the west hall. Since being on this hall she has not had any problems with her peers. She has adjusted well to her new roommate. Zero conflicts have been reported. [Client B] has also reportedly slept well on night shift. When on the north unit she had some restlessness at times. The staff has not seen this on the west hall. The nurse stated that [client B] normally is sleeping when she brings the medication to her</p>		<p>completed within one week. The policy for abuse and neglect was retrained with Client Advocates and Program Directors. The Client Advocates have been trained by a Golden Living Corporate employee. Each resident has been assessed as to their elopement risk and need of service by an electronic system. For those deemed to be at risk for elopement and in need of it, an electronic system has been proposed via a Capital Expense Request to be installed at North Willow which includes alarms, and locks along with personal monitors for those assessed to need them. The quote for this system is available upon request.</p> <p>IV Monitoring Corrective Measures: Program Directors review BIR reports and assure follow up recommendations are completed for the IDT. Upon installation of the electronic monitoring system, staff will be trained in its use and QMRP staff trained as to the parameters that require its</p>		

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	<p>roommate. It is not known why [client B] was up this particular morning. Staff did not see anyone wander into [client B's] room that night. [Client B] had rested well through the night shift...None of the clients interviewed had seen anyone be mean to or try to harm [client B]. Conclusion: [Client B] has existing diagnosis of osteoporosis. It is being treated with Fosamax, and calcium with vitamin D. [Client B] gets tested for bone density every 2 years. A diagnosis of osteoporosis puts [client B] at risk for fractures. There are plans in place for [client B's] risk for falls, her risk for fractures related to falls and bone weakness, and her risk for pain related to osteoporosis....[Client B's] fractures were repaired on Sept. (September) 30th. It is possible when [client B] sat herself down the morning of the 30th that she fractured the bones at that time. [Client B] had multiple falls in August. Zero falls in September...."</p> <p>The facility's undated investigation indicated LPN #1 was interviewed on 9/30/11 in regard to client B's fractures. The 9/30/11 witness statement indicated "...[Client B] was (up) on her feet (with) walker & asking for pen. I thought she was having a behavior because I wouldn't give her my pen. She went down to the floor and would not get back (up). I</p>		<p>need. During Daily QAA packets of information will be reviewed in detail to assure thoroughness. A policy has been drafted which addresses elopement. As specified in statements; completed by 12-9-11.</p>		

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	<p>thought was behavior. I went & got CNA [CNA #2] to help me get [client B] (up). We went back in & she was on the floor still. We tried to help her (up) & she acted as if she she couldn't bare (sic) weight on her (R) leg. I noted she had ted hose on & (and) legs were swollen both swollen. One of us got on each side of her & helped her (up) & sat on her bed (sic) the (sic) right leg was so edematous & just above the ankle her leg looked extremely swollen when palpated justed (sic) above R (right) ankle she would grimace & grunt or make noises that let me know she was in pain-both legs were swollen but (R) leg was def (definitely) significantly more swollen...." LPN #1's witness statement indicated she did not recall if there was a floor mat by client B's bed. LPN #1's witness statement indicated client B had been sleeping through the night in the past, and this was the first time client B was up with her walker when the LPN entered the bedroom. LPN #1's 9/30/11 witness statement did not indicate what position client's B's legs were in when she sat herself down on the floor and/or what position they were in when she went to examine the client. LPN #1's witness statement did not include any additional information in regard to the incident.</p> <p>The facility's 9/30/11 through 10/4/11</p>				

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	<p>dated witness statements indicated the facility interviewed 13 CNAs and/or nurses who had worked with client B on the west hallway and the north hallway. The facility's undated investigation of the 9/30/11 incident indicated the facility did not interview CNA #2 who assisted the LPN to get client B up off the floor.</p> <p>Client B's record was reviewed on 11/1/11 at 11:50 AM. Client B's 9/30/11 History and Physical indicated client B had an "Acute fracture of distal tibia and fibula." Client B's 9/30/11 X-ray of her both her lower legs indicated "Findings: "Acute oblique fractures of the distal tibia and fibula are present. The tibia fracture is approximately 7 cm (centimeters) above the ankle joint, and the fibular fracture is approximately 3.5 cm. Placement and mild overriding can be seen. No significant angulation is noted. Also identified is a healing fracture of the proximal fibula with exuberant callus formation around the fracture site. Impression: 1. Acute fractures of distal tibia and fibula. 2. Healing fracture of proximal fibula (fracture below knee area)."</p> <p>Client B's 10/1/11 Procedure Note indicated "...The patient presented to the [name of hospital] Emergency Room after a fall. There were no details in regards to</p>				

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	<p>the injury...." The Procedure Note indicated nails were placed in client B's right tibia due to the fracture. The Procedure Note indicated during the procedure an X-ray was obtained. The Procedure Note indicated "...The x-ray was used to obtain permanent records at the knee fracture and ankle area,...."</p> <p>Client B's 10/2/11 Discharge Summary indicated "...The patient was admitted to the hospital on September 30, 2011, after being found by staff at the nursing home with an inability to walk and right leg swelling...."</p> <p>The facility's 9/30/11 reportable incident report and/or investigation failed to indicate client B had a fracture near the knee area. The facility's 9/30/11 reportable incident report and/or investigation indicated the facility failed to investigate the knee fracture/injury of unknown origin.</p> <p>Client B's 10/3/11 Behavior Incident Report (BIR) indicated "As I was giving [client B] a bath I noticed she has bruises al (sic)-4 areas of her body, the rt (right) thigh, left thigh, rt lower abd (abdomen) and upper abd. Noticed that she has also found it difficult to lift her rt hand up. The nurse was notified of the finding." At the top of the 10/3/11 BIR was hand</p>				

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	<p>written "Known Bruises" which was underlined.</p> <p>Client B's nursing notes for 9/11 to 10/11 did not indicate the above mentioned 10/3/11 bruises/injuries had been documented and/or reason for the bruising documented by the facility's nursing staff. Client B's record and/or facility's reportable incident reports did not indicate/mention the client's bruising found on 10/3/11.</p> <p>Client B's BIRs indicated the following behaviors:</p> <p>-9/7/11 client B was asked to go to the bathroom. The BIR indicated client B "...refused, sat on floor,...."</p> <p>-8/30/11 client B was waiting for the elevator when the client indicated she wanted to walk. The BIR indicated the staff moved the walker up to client B and client B "...pointed to sitting, and slid down wall to sit on the floor...."</p> <p>-8/31/11 client B stood up from the wheelchair and sat on the floor on her buttocks.</p> <p>-8/11/11 client B threw her walker and when redirected to pick it up, the client "...starts with her screaming and throws</p>			

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	<p>herself on the floor."</p> <p>Client B's interdisciplinary team meeting notes indicated the following:</p> <p>-10/2/11 client B had been sent out to the hospital due to the client's "inability to bear weight," and it was found the client had a compound fracture which required pin placement. The IDT note indicated client B was returned to the facility on a Saturday and it was discovered on Sunday the client had removed part of the dressing from her operative site. The IDT note indicated client B was placed on one to one staffing (one staff to one client), during awake hours and 15 minute checks at night, to prevent this from happening again.</p> <p>-10/6/11 client B's IDT met and put in place a care plan for the client. The IDT note indicated a geri-chair would be used for mobility purposes since the client could not bear weight. The IDT note indicated a three person transfer protocol would be used when transferring the client.</p> <p>Client B's 10/3/10 Individual Support Plan (ISP) indicated client B's diagnoses included, but were not limited to, Osteoporosis and Cerebral Palsy. Client B's 4/18/11 Behavior Management Plan</p>				

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	<p>(BMP) indicated client B demonstrated AWOL (absence without leave), property destruction, physical aggression, self-injurious behavior (SIB) and temper tantrums/agitation. Client B's BMP defined the client's SIB as "Includes, but is not limited to picking and scratching at her skin, hitting/kicking walls, doors and tables and pulling her hair and biting herself." The BMP defined the client's temper tantrum as "Includes, but is not limited to screaming, loud nonsensical sounds, stomping feet, and crying pounding on doors and windows...."</p> <p>Client B's above mentioned IDT notes, 10/3/10 ISP and/or BMP did not identify and/or address the client's behavior of throwing herself to and/or sitting herself on the floor to prevent fractures.</p> <p>Interview with LPN #2 on 10/25/11 at 9:31 AM indicated client B was found on the floor getting out of bed. LPN #2 indicated the client was sent out to the ER for evaluation. LPN #2 indicated client B did not have a history of falling out of the bed.</p> <p>Interview with CNA #3 on 10/25/11 at 6:19 PM indicated client B would ask others for pens. CNA #3 stated client B had fallen "hard to floor" when she fell in the dining room a several months ago. CNA #3 indicated client B received a cut</p>				

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	<p>to her face but did not fracture anything.</p> <p>Interview with CNA#7 on 10/25/11 at 6:30 PM indicated indicated CNA #7 was not aware of any falls with client B since the client moved to the west hall. CNA #7 stated "She busted her head" 2 months ago when she fell. CNA #7 indicated client B was getting along with her roommate.</p> <p>Interview with CNA #5 on 10/25/11 at 6:37 PM indicated client B had been having problems with ambulation. CNA #5 indicated client B slept at night and would only get up to go to the bathroom. CNA #5 indicated they saw client B fall in the dining room where the client hit her face/head on a brick wall. CNA #5 indicated this incident occurred a few months ago.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/1/11 at 12:45 stated client B was "non weight bearing" and the client had one to one staffing at this time. QMRP #1 indicated client B did not have a history of placing herself on the floor. QMRP #1 stated "It might happen in the midst of a behavior but mostly a fall. She will not actually place herself on the floor." QMRP #1 stated client B was using a walker and a wheelchair as the client "was</p>				

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	<p>having balance and unsteady issues." QMRP #1 indicated the client had moved from the north hall to the west hall a couple days prior to her fractures. QMRP #1 indicated she was not aware client B had a fracture near her knee area. When asked how client B received the bruises on 10/3/11, QMRP #1 indicated she was told they were from surgery. QMRP #1 indicated the information in regard to the bruising should be documented in the nursing notes of the client's record. QMRP #1 indicated client B's 10/10 ISP did not address the client's putting herself/sitting on the floor.</p> <p>Interview with administrative staff #7 on 11/1/11 at 12:50 PM indicated the administrative staff had not seen client B put herself and/or sit on the floor.</p> <p>Interview with administrative staff #5 on 11/1/11 at 3:26 PM indicated she was not aware client B had a fracture to her proximal fibula (knee area) as she had not seen the x-ray report. When shown the x-ray report, administrative staff #5 stated "It is definitely two different fractures."</p> <p>Interview with administrative staff #4 on 11/1/11 at 3:45 PM stated "It was not clear how [client B] sat down on the floor." Administrative staff #4 stated "She (LPN #1) did not know where her</p>				

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	<p>feet were. The nurse was not clear about anything." Administrative staff #4 indicated she interviewed staff on the north and the west halls in regard to client B's injuries. Administrative staff #4 indicated client B was moved from the north hall to the west hall as the client was having problems with her roommate. When asked when client B fractured her proximal fibula (knee), administrative staff #4 stated "I don't know. We thought a spiral fracture, but cannot find documentation." Administrative staff #4 indicated the facility felt client B's fracture was due to her sitting down on the floor as there was nothing else to explain the injuries/fracture. Administrative staff #4 indicated the facility did not conduct an investigation in regard to the proximal fracture. When asked how client B received the 10/3/11 bruises, administrative staff #4 stated the bruises were from "surgery due to giving the client blood thinner injections. These were acceptable sites for injuries." Administrative staff #4 indicated she was not able to locate any documentation in regard to the investigation/explanation for the bruises. Administrative staff #4 indicated client B's bruises and explanation should have been documented in the client's record.</p> <p>Interview with administrative staff #1, #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 11/09/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN46260		
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	<p>and #3 on 11/1/11 at 5:40 PM indicated the facility investigated client B's fractures. Administrative staff #2 stated they thought the client's fractures were a "spiral fracture." Administrative staff #2 and #3 were not sure why the facility thought it was a spiral fracture as a spiral fracture was not documented in the client's record. Administrative staff #2 indicated it was believed client B's fractures to the tibia and fibula at the ankle were due to the client's sitting down on the floor. Administrative staff #2 stated client B could "easily fracture" as the client had osteoporosis. Administrative staff #1 indicated the second fracture should have been investigated. Administrative staff #1, #2 and #3 indicated they were not aware client B had placed and/or sat herself on the floor in the past.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/25/11 at 11:25 AM. The facility's 10/6/11 reportable incident report indicated "Resident (client D) eloped from the facility. Amber alert called...AVS (workshop) supervisor, ED (Executive Director), Program Director and CNA located residentialmost (sic) immediately behind facility. Resident returned with staff willingly to facility. Body assessment completed with no</p>				

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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, IN46260		
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	<p>injury noted. Resident was placed on 15 min. (minute) checks. Building hall monitor initiated to watch first floor exits. Team will meet further to discuss plan."</p> <p>The facility's 10/12/11 follow-up report indicated "[Client D] left the building without permission. She has been sitting at the front desk talking to the receptionist which she frequently does. When staff went to look for her for lunch and she was not found, an amber alert was initiated. [Client D] was found by staff 0.2 miles from facility...Staff report that resident was visiting receptionist sitting at the front desk. Staff report that she seemed fine without signs of agitation. Nursing reports [client D] had taken her meds and was seen walking into the dining area approximately 10 minutes prior to elopement. Program Director reports that [client D] had been attempting to talk to ED and that ED had been busy in meetings during the morning. PD (Program Director) reports that [client D] was unhappy about having to wait to talk to ED. Per investigation, [client D] spoke with ED at approximately 11:33 AM, and staff began looking for her at 11:35 AM. Resident arrived back at the facility at 11:53 AM." The 10/12/11 follow-up report indicated client B was placed on 15 minute checks with a monitor at the front door for 72 hours. The follow-up report</p>				

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	<p>indicated "...The following are recommendations agreed upon by the team: Per [client D's] Behavior Support Plan, she is to make an appointment to speak to the administrator. [Client D] will be encouraged to remain in her assigned area and participate in group activities. Her BSP (Behavior Support Plan) will be revised to include reinforcers she can earn for participating in active treatment and remaining in her assigned area. If [client D] does sit at the front desk conversing with the receptionist, she will be on 5 minute checks. All her staff will be trained on changes in her BSP."</p> <p>A 10/6/11 witness statement by the receptionist indicated an "amber alert" (code to tell staff a client could not be located in the building) was called over the intercom. The witness statement indicated another staff person who was on their way home called back to the facility to tell the receptionist she saw one of the clients.</p> <p>During the 10/25/11 observation period between 6:30 AM and 10:00 AM, at the facility, there was no door monitor at the front door of the facility at 6:30 AM. At 6:47 AM, a staff person was sitting at the front desk area monitoring the doors. Interview with CNA #6 on 10/25/11 at</p>				

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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, IN46260		
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	<p>6:47 AM indicated she was working as a door/hall monitor. During the 10/25/11 observation period, client D utilized a roller walker when ambulating.</p> <p>Client D's record was reviewed on 11/1/11 at 9:14 AM. Client D's 10/6/11 BIR indicated "Clt (client) had been trying to talk w/ (with) ED throughout the morning hours & was upset that ED was busy in mtgs (meetings). When staff were unable to locate [client D] amber alert was called. Staff were searching the neighborhood immediately behind the facility...[Client D] indicated she just wanted some fresh air...door monitor was implemented & nursing completed an assessment on her w/ 0 (zero) issues found."</p> <p>Client D's 10/7/11 Interdisciplinary Team Plan (IDP) note indicated the client's IDP met to review the 10/6/11 elopement incident. Client D's IDP note indicated "...Per interview with [client D], she eloped due to being upset over wanting to speak with ED and was unable to do so due to the ED being involved in meetings. [Client D] was immediately placed on 15-minute checks for 24 hours and a door monitor was established on the first floor..." The IDP note indicated client D had to make an appointment to speak with the ED. The 10/7/11 IDP note indicated</p>				

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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, IN46260		
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	<p>client D liked sitting up in the front area near the receptionist desk and the front door. The IDP note indicated client D would no longer be physically escorted from the area, but would be placed on a reinforcer program which would reward the client for staying in her area. The IDP note indicated "...4. [Client D's] plan will also be updated to include how staff are to monitor [client D] if she decides to sit with the receptionist. The team feels at this time that it is appropriate for [client D] to be placed on 5-minute checks during these time frames. Again, all of [client D's] staff will be trained on this added component...."</p> <p>Client D's 9/13/11 5 minute check forms indicated the facility had documentation of 5 minute checks for 9/13/11 from 11:15 AM to 11:25 AM. No additional checks and/or documentation were provided in regard to when 5 minute checks had been completed.</p> <p>The facility's inservice training records were reviewed on 11/1/11 at 11:19 AM. The facility's 10/13/11 inservice record indicated facility staff were trained on client D's 10/7/11 IDP plan addendum in regard to client D's reinforcer program, 2 person escort being removed from her plan and being placed on 5 minute checks. The 10/13/11 inservice record indicated 4</p>				

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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, IN46260		
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	<p>staff (CNA #9, CNA #10, CNA #11 and CNA #12) had not been trained in regard to the client's IDP addendum which included 5 minute checks.</p> <p>Client D's 2/3/11 Individual Program Plan (IPP) indicated client D's diagnoses included, but were not limited to, Cerebral Palsy and Convulsions. Client D's IPP indicated the client utilized a walker, cane and/or a wheelchair for ambulation due to the client's CP and unsteady gait. Client D's IPP also indicated the client was at risk for falls. Client D's 6/6/11 care plan for falls indicated the client had a history of falls with and without injuries. The 6/6/11 care plan indicated "Keep resident in sight of CNA/staff at all times when out of bed." Client D also had a care plan dated 6/6/11 for elopement. The 6/6/11 plan indicated client D should be redirected from doors.</p> <p>The facility's reportable incident reports from 8/11 to 10/11 indicated client D fell on 8/29/11, 9/13/11, 9/18/11, 9/25/11 and 10/7/11.</p> <p>Interview with administrative staff #6 and Qualified Mental Retardation Professional (QMRP) #2 on 11/1/11 at 11:05 AM indicated client D had a history of eloping from the facility and/or attempting to elope. Administrative staff #6 indicated</p>				

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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, IN46260
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	<p>client D would like to sit up front in the office area which was near the main doors. Administrative staff #6 indicated client D would attempt to elope when the client was upset. Administrative staff #6 indicated client D's 8/30/11 interdisciplinary team note indicated staff were to keep the client in line of sight when she was agitated to prevent the client from eloping. Administrative staff #6 indicated client D had left the front desk area and walked back toward the dining room area. Administrative staff #6 indicated client D was wanting to speak with the ED and became upset when she could not speak with her. Administrative staff #6 indicated client D then eloped from the facility via the main doors of the facility. Administrative staff #6 stated there was a "break down in communication" as staff was not aware client D was mad at the ED on 10/6/11. Administrative staff #6 and QMRP #2 stated client D was found in the neighborhood behind the facility which was "approximately 2 tenths of a mile from the facility." Administrative staff #6 indicated she thought it would take client D 3 to 4 minutes to walk to point where she was found with a walker. Administrative staff #6 and QMRP #2 indicated the client had walked around the curb. Administrative staff #6 and QMRP #2 indicated there had not been any other</p>			

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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, IN46260		
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	<p>elopements since the 10/6/11 incident. Administrative staff #6 indicated facility staff were to conduct 5 minute checks with client D when sat up near the receptionist area. QMRP #2 indicated facility staff had to conduct 5 minute checks on client D since the 10/6/11 elopement. QMRP #6 stated the QMRP was "not consistently getting the checks." QMRP #6 indicated the staff/CNAs were documenting the 5 minute checks when they were being conducted.</p> <p>Administrative staff #6 indicated the CNAs/staff were to document the 5 minute checks when conducted.</p> <p>Administrative staff #6 indicated she was not able to locate any additional documentation to show all staff had been trained in regard to client D's 10/7/11 addendum which included conducting 5 minute checks.</p> <p>Interview with administrative staff #1, #2 and #3 on 11/1/11 at 5:10 PM indicated client D had a history of eloping from the building with and/or without staffs' knowledge. Administrative staff #1 indicated client D was moved to the first floor due to going AWOL from the third floor using the stairwell with her ambulation/gait issues. Administrative staff #1 indicated client D was found in the neighborhood behind the facility.</p> <p>Administrative staff #1 indicated client D</p>				

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W0154	<p>eloped out of the main front door. Administrative staff #1 indicated client D was agitated when she eloped on 10/6/11.</p> <p>The facility's policy and procedures were reviewed on 10/25/11 at 7:24 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The policy indicated "The facility makes reasonable efforts to determine the cause of the alleged violation and takes corrective action consistent with the investigative findings and to eliminate any ongoing dangers to the resident...."</p> <p>This federal tag relates to complaints #IN00098167 and #IN00098684.</p> <p>3.1.28(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 14 allegations of abuse/neglect and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to client B's fractures/injuries of unknown origin.</p> <p>Findings include:</p>	W0154	<p>W154</p> <p>I Corrective Action for Cited Clients:</p> <p>Client B's IDT has developed a plan related to her sitting on the floor as a behavior. The investigation of Client B's fracture was reopened</p>	12/09/2011	

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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, IN46260		
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	The facility's reportable incident reports and/or investigations were reviewed on 10/25/11 at 11:25 AM. The facility's 9/30/11 reportable incident report indicated "Swelling noted in RT (right)/leg unable to bear wt. (weight). MD (medical doctor) notified. Sent to ER via ambulance. The 10/7/11 follow-up report indicated "[Client B] presented with edema to her lower extremities. The right leg was more swollen then the left. [Client B] also presented with guarding of her right leg not wanting to bear weight. X-rays were done at the hospital. Results reflected fracture of distal tibia and fibula (closer to the ankle)...The night nurse reported that she went into [client B's] room in the morning to administer medication to [client B's] roommate. The nurse reports that [client B] was awake already standing up beside her bed with her walker beside of her. [Client B] began to ask the nurse for pens (usual behavior) through her sign language and gesturing. The nurse reports that when she told [client B] she did not have a pen for that [client B] sat herself down to the floor. The nurse did not notice if [client B] sat on her foot or not. She continued to give the medication to the roommate. After she had completed administering the medication she then went to [client B] and instructed her to get up. The nurse offered to help her up off the floor.		and reinvestigated with follow up completed as appropriate. The other fracture has been investigated. The 10-3-11 incident of unknown bruising has been reopened and further investigation completed. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: QMRPs were trained that after an IDT has identified follow up action/training, this action/training must be completed within one week. The policy for abuse and neglect was retrained with Client Advocates and Program Directors. The Client Advocates have been trained by Yvonne Tanner(need her title, delete name). Each resident has been assessed as to their elopement risk and need of service by an electronic system. For those deemed to be at risk for elopement and in need of it, an electronic system has been proposed via a Capital Expense Request to be		

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	<p>[Client B] normally can get up all by herself. The nurse stated she thought [client B] was having a behavior. [Client B] acted as if she could not get up. The nurse went and got staff to help her with [client B]. The nurse and the CNA (certified nurse aide) assisted [client B] up to her bed. The right ankle also had discoloration around it. [Client B] was sent to the hospital for evaluation and treatment.</p> <p>The staff reported that [client B] has recently moved to the west hall. Since being on this hall she has not had any problems with her peers. She has adjusted well to her new roommate. Zero conflicts have been reported. [Client B] has also reportedly slept well on night shift. When on the north unit she had some restlessness at times. The staff has not seen this on the west hall. The nurse stated that [client B] normally is sleeping when she brings the medication to her roommate. It is not known why [client B] was up this particular morning. Staff did not see anyone wander into [client B's] room that night. [Client B] had rested well through the night shift...None of the clients interviewed had seen anyone be mean to or try to harm [client B]. Conclusion: [Client B] has existing diagnosis of osteoporosis. It is being treated with Fosamax, and calcium with</p>		<p>installed at North Willow which includes alarms, and locks along with personal monitors for those assessed to need them.</p> <p>IV Monitoring Corrective Measures: Program Directors review BIR reports and assure follow up recommendations are completed for the IDT. Upon installation of the electronic monitoring system, staff will be trained in its use and QMRP staff trained as to the parameters that require its need. During Daily QAA packets of information will be reviewed in detail to assure thoroughness. A policy has been drafted which addresses elopement. As specified in statements; completed by 12-9-11.</p>		

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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, IN46260
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	<p>vitamin D. [Client B] gets tested for bone density every 2 years. A diagnosis of osteoporosis puts [client B] at risk for fractures. There are plans in place for [client B's] risk for falls, her risk for fractures related to falls and bone weakness, and her risk for pain related to osteoporosis....[Client B's] fractures were repaired on Sept. (September) 30th. It is possible when [client B] sat herself down the morning of the 30th that she fractured the bones at that time. [Client B] had multiple falls in August. Zero falls in September...."</p> <p>The facility's undated investigation indicated LPN #1 was interviewed on 9/30/11 in regard to client B's fractures. The 9/30/11 witness statement indicated "...[Client B] was (up) on her feet (with) walker & asking for pen. I thought she was having a behavior because I wouldn't give her my pen. She went down to the floor and would not get back (up). I thought was behavior. I went & got CNA [CNA #2] to help me get [client B] (up). We went back in & she was on the floor still. We tried to help her (up) & she acted as if she she couldn't bare (sic) weight on her (R) leg. I noted she had ted hose on & (and) legs were swollen both swollen. One of us got on each side of her & helped her (up) & sat on her bed (sic) the (sic) right leg was so edematous</p>			

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	<p>& just above the ankle her leg looked extremely swollen when palpated justed (sic) above R (right) ankle she would grimace & grunt or make noises that let me know she was in pain-both legs were swollen but (R) leg was def (definitely) significantly more swollen...." LPN #1's witness statement indicated she did not recall if there was a floor mat by client B's bed. LPN #1's witness statement indicated client B had been sleeping through the night in the past, and this was the first time client B was up with her walker when the LPN entered the bedroom. LPN #1's 9/30/11 witness statement did not indicate what position client's B's legs were in when she sat herself down on the floor and/or what position they were in when she went to examine the client. LPN #1's witness statement did not include any additional information in regard to the incident.</p> <p>The facility's 9/30/11 through 10/4/11 dated witness statements indicated the facility interviewed 13 CNAs and/or nurses who had worked with client B on the west hallway and the north hallway. The facility's undated investigation of the 9/30/11 incident indicated the facility did not interview CNA #2 who assisted the LPN to get client B up off the floor.</p> <p>Client B's record was reviewed on 11/1/11</p>				

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	<p>at 11:50 AM. Client B's 9/30/11 History and Physical indicated client B had an "Acute fracture of distal tibia and fibula." Client B's 9/30/11 X-ray of her both her lower legs indicated "Findings: "Acute oblique fractures of the distal tibia and fibula are present. The tibia fracture is approximately 7 cm (centimeters) above the ankle joint, and the fibular fracture is approximately 3.5 cm. Placement and mild overriding can be seen. No significant angulation is noted. Also identified is a healing fracture of the proximal fibula with exuberant callus formation around the fracture site. Impression: 1. Acute fractures of distal tibia and fibula. 2. Healing fracture of proximal fibula (fracture below knee area)."</p> <p>Client B's 10/1/11 Procedure Note indicated "...The patient presented to the [name of hospital] Emergency Room after a fall. There were no details in regards to the injury...." The Procedure Note indicated nails were placed in client B's right tibia due to the fracture. The Procedure Note indicated during the procedure an X-ray was obtained. The Procedure Note indicated "...The x-ray was used to obtain permanent records at the knee fracture and ankle area,...."</p> <p>Client B's 10/2/11 Discharge Summary</p>				

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	<p>indicated "...The patient was admitted to the hospital on September 30, 2011, after being found by staff at the nursing home with an inability to walk and right leg swelling...."</p> <p>The facility's 9/30/11 reportable incident report and/or investigation failed to indicate client B had a fracture near the knee area. The facility's 9/30/11 reportable incident report and/or investigation indicated the facility failed to investigate the knee fracture/injury of unknown origin.</p> <p>Client B's 10/3/11 Behavior Incident Report (BIR) indicated "As I was giving [client B] a bath I noticed she has bruises al (sic)-4 areas of her body, the rt (right) thigh, left thigh, rt lower abd (abdomen) and upper abd. Noticed that she has also found it difficult to lift her rt hand up. The nurse was notified of the finding." At the top of the 10/3/11 BIR was hand written "Known Bruises" which was underlined.</p> <p>Client B's nursing notes for 9/11 to 10/11 did not indicate the above mentioned 10/3/11 bruises/injuries had been documented and/or reason for the bruising documented by the facility's nursing staff. Client B's record and/or facility's reportable incident reports did not</p>				

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	<p>indicate/mention the client's bruising found on 10/3/11.</p> <p>Interview with LPN #2 on 10/25/11 at 9:31 AM indicated client B was found on the floor getting out of bed. LPN #2 indicated the client was sent out to the ER for evaluation. LPN #2 indicated client B did not have a history of falling out of the bed.</p> <p>Interview with CNA #3 on 10/25/11 at 6:19 PM indicated client B would ask others for pens. CNA #3 stated client B had fallen "hard to floor" when she fell in the dining room a several months ago. CNA #3 indicated client B received a cut to her face but did not fracture anything.</p> <p>Interview with CNA#7 on 10/25/11 at 6:30 PM indicated indicated CNA #7 was not aware of any falls with client B since the client moved to the west hall. CNA #7 stated "She busted her head" 2 months ago when she fell. CNA #7 indicated client B was getting along with her roommate.</p> <p>Interview with CNA #5 on 10/25/11 at 6:37 PM indicated client B had been having problems with ambulation. CNA #5 indicated client B slept at night and would only get up to go to the bathroom. CNA #5 indicated they saw client B fall in</p>				

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	<p>the dining room where the client hit her face/head on a brick wall. CNA #5 indicated this incident occurred a few months ago.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/1/11 at 12:45 stated client B was "non weight bearing" and the client had one to one staffing at this time. QMRP #1 indicated client B did not have a history of placing herself on the floor. QMRP #1 stated "It might happen in the midst of a behavior but mostly a fall. She will not actually place herself on the floor." QMRP #1 stated client B was using a walker and a wheelchair as the client "was having balance and unsteady issues." QMRP #1 indicated the client had moved from the north hall to the west hall a couple days prior to her fractures. QMRP #1 indicated she was not aware client B had a fracture near her knee area. When asked how client B received the bruises on 10/3/11, QMRP #1 indicated she was told they were from surgery. QMRP #1 indicated the information in regard to the bruising should be documented in the nursing notes of the client's record.</p> <p>Interview with administrative staff #7 on 11/1/11 at 12:50 PM indicated the administrative staff had not seen client B put herself and/or sit on the floor.</p>			

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	<p>Interview with administrative staff #5 on 11/1/11 at 3:26 PM indicated she was not aware client B had a fracture to her proximal fibula (knee area) as she had not seen the x-ray report. When shown the x-ray report, administrative staff #5 stated "It is definitely two different fractures."</p> <p>Interview with administrative staff #4 on 11/1/11 at 3:45 PM stated "It was not clear how [client B] sat down on the floor." Administrative staff #4 stated "She (LPN #1) did not know where her feet were. The nurse was not clear about anything." Administrative staff #4 indicated she interviewed staff on the north and the west halls in regard to client B's injuries. Administrative staff #4 indicated client B was moved from the north hall to the west hall as the client was having problems with her roommate. When asked when client B fractured her proximal fibula (knee), administrative staff #4 stated "I don't know. We thought a spiral fracture, but cannot find documentation." Administrative staff #4 indicated the facility felt client B's fracture was due to her sitting down on the floor as there was nothing else to explain the injuries/fracture. Administrative staff #4 indicated the facility did not conduct an investigation in regard to the proximal fracture. When</p>			

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	<p>asked how client B received the 10/3/11 bruises, administrative staff #4 stated the bruises were from "surgery due to giving the client blood thinner injections. These were acceptable sites for injuries." Administrative staff #4 indicated she was not able to locate any documentation in regard to the investigation/explanation for the bruises. Administrative staff #4 indicated client B's bruises and explanation should have been documented in the client's record.</p> <p>Interview with administrative staff #1, #2 and #3 on 11/1/11 at 5:40 PM indicated the facility investigated client B's fractures. Administrative staff #2 stated they thought the client's fractures were a "spiral fracture." Administrative staff #2 and #3 were not sure why the facility thought it was a spiral fracture as a spiral fracture was not documented in the client's record. Administrative staff #2 indicated it was believed client B's fractures to the tibia and fibula at the ankle were due to the client's sitting down on the floor. Administrative staff #2 stated client B could "easily fracture" as the client had osteoporosis. Administrative staff #1 indicated the second fracture should have been investigated.</p> <p>This federal tag relates to complaint</p>				

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W0227	<p>#IN00098684.</p> <p>3.1-28(d)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 4 sampled clients (B), the client's Individual Support Plan (ISP) failed to address the client's identified need of sitting herself on/throwing herself to the floor.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/25/11 at 11:25 AM. The facility's 9/30/11 reportable incident report indicated "Swelling noted in RT (right)/leg unable to bear wt. (weight). MD (medical doctor) notified. Sent to ER via ambulance. The 10/7/11 follow-up report indicated "[Client B] presented with edema to her lower extremities. The right leg was more swollen then the left. [Client B] also presented with guarding of her right leg not wanting to bear weight. X-rays were done at the hospital. Results reflected fracture of distal tibia and fibula (closer to the ankle)...The night nurse reported that she went into [client B's]</p>	W0227	<p>W227</p> <p>I Corrective Action for Cited Clients:</p> <p>Client B's IDT has developed a plan related to her sitting on the floor as a behavior.</p> <p>II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice.</p> <p>III Corrective Measures or Systemic Changes: QMRPs were trained that after an IDT has identified follow up action/training, this action/training must be completed within one week. QMRPs have been retrained that when a behavior occurs three or more times within a 30 day period the IDT must develop a plan to address the issue.</p> <p>IV Monitoring Corrective Measures:</p>	12/09/2011

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	<p>room in the morning to administer medication to [client B's] roommate. The nurse reports that [client B] was awake already standing up beside her bed with her walker beside of her. [Client B] began to ask the nurse for pens (usual behavior) through her sign language and gesturing. The nurse reports that when she told [client B] she did not have a pen for that [client B] sat herself down to the floor...."</p> <p>"The staff reported that [client B] has recently moved to the west hall. Since being on this hall she has not had any problems with her peers. She has adjusted well to her new roommate. Zero conflicts have been reported. [Client B] has also reportedly slept well on night shift. When on the north unit she had some restlessness at times. The staff has not seen this on the west hall. The nurse stated that [client B] normally is sleeping when she brings the medication to her roommate. It is not known why [client B] was up this particular morning. Staff did not see anyone wander into [client B's] room that night. [Client B] had rested well through the night shift...None of the clients interviewed had seen anyone be mean to or try to harm [client B]. Conclusion: [Client B] has existing diagnosis of osteoporosis. It is being treated with Fosamax, and calcium with</p>		<p>Program Directors review BIR reports and assure follow up recommendations are completed for the IDT. To be completed by 12-9-11.</p>		

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	<p>vitamin D. [Client B] gets tested for bone density every 2 years. A diagnosis of osteoporosis puts [client B] at risk for fractures. There are plans in place for [client B's] risk for falls, her risk for fractures related to falls and bone weakness, and her risk for pain related to osteoporosis....[Client B's] fractures were repaired on Sept. (September) 30th. It is possible when [client B] sat herself down the morning of the 30th that she fractured the bones at that time...."</p> <p>Client B's record was reviewed on 11/1/11 at 11:50 AM. Client B's BIRs indicated the following behaviors:</p> <p>-9/7/11 client B was asked to go to the bathroom. The BIR indicated client B "...refused, sat on floor,...."</p> <p>-8/30/11 client B was waiting for the elevator when the client indicated she wanted to walk. The BIR indicated the staff moved the walker up to client B and client B "...pointed to sitting, and slid down wall to sit on the floor...."</p> <p>-8/31/11 client B stood up from the wheelchair and sat on the floor on her buttocks.</p> <p>-8/11/11 client B threw her walker and when redirected to pick it up, the client</p>				

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	<p>"...starts with her screaming and throws herself on the floor."</p> <p>Client B's 10/3/10 Individual Support Plan (ISP) indicated client B's diagnoses included, but were not limited to, Osteoporosis and Cerebral Palsy. Client B's 4/18/11 Behavior Management Plan (BMP) indicated client B demonstrated AWOL (absence without leave), property destruction, physical aggression, self-injurious behavior (SIB) and temper tantrums/agitation. Client B's BMP defined the client's SIB as "Includes, but is not limited to picking and scratching at her skin, hitting/kicking walls, doors and tables and pulling her hair and biting herself." The BMP defined the client's temper tantrum as "Includes, but is not limited to screaming, loud nonsensical sounds, stomping feet, and crying pounding on doors and windows...."</p> <p>Client B's above mentioned IDT notes, 10/3/10 ISP and/or BMP did not identify and/or address the client's behavior of throwing herself to and/or sitting herself on the floor to prevent fractures.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/1/11 at 12:45 stated client B was "non weight bearing" and the client had one to one staffing at this time. QMRP #1 indicated client B did not have a history of</p>				

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	<p>placing herself on the floor. QMRP #1 stated "It might happen in the midst of a behavior but mostly a fall. She will not actually place herself on the floor." QMRP #1 stated client B was using a walker and a wheelchair as the client "was having balance and unsteady issues." QMRP #1 indicated client B's 10/10 ISP did not address the client's putting herself/sitting on the floor.</p> <p>This federal tag relates to complaint #IN00098684.</p> <p>3.1-35(a)</p>				