

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN46203
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: November 28,29,30, and December 1, 2011</p> <p>Facility Number: 000063 Provider Number: 155138 AIM Number:100266210</p> <p>Survey Team: Elizabeth Kolasa RN, TC Patti Allen BSW Marcy Smith RN (December 1, 2011) Leia Alley RN (November 28, 30 and December 1, 2011) Barbara Hughes RN Karina Gates (November 28, and December 1, 2011) Courtney Mujic RN (November 28, and December 1, 2011)</p> <p>Census Bed Type: SNF/NF: 86 Total: 86</p> <p>Census Payor Type: Medicare: 16 Medicaid: 62 Other: 8 Total: 86</p>	F0000		

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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F0282 SS=D	<p>Sample: 18</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/7/11 Cathy Emswiller RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 13 residents, reviewed for physician orders, in a total sample of 18. (Resident #29)</p> <p>Findings include: The clinical record for Resident #29 was reviewed on 11/28/11 at 1:30 p.m.</p> <p>The diagnosis for Resident #29 included, but was not limited to: diabetes mellitus.</p> <p>Recapitulation of the November Physician Orders, indicated Novolog (insulin treatment of blood glucose levels) was to be given per sliding scale of subsequent blood sugars (BS) from an Accucheck measurement. The sliding scale was BS 140-200=2 units of Novolog, BS of 201-250= 4 units of Novolog, BS of 251-300=6 units of Novolog, BS of</p>	F0282	<p>Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F282 Corrective action: Insulin orders of resident #29 were reviewed and discussed with MD and modified per MD orders.</p> <p>Other residents affected: No other resident was identified as being affected by the alleged deficient practice.</p> <p>Systemic changes: Facility wide audit completed to ensure no other residents are affected. Licensed nurses were re-educated on proper procedures for following sliding</p>	12/31/2011	

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	<p>301-350= 9 units of Novolog, and 351-400=12 units of Novolog, greater than 400 give 14 units and call MD (medical doctor).</p> <p>On the November Diabetic Monitoring Flowsheet, there was no treatment or indication that Novolog was given on the following dates that required Novolog coverage according to the physician order 11/1/11 5:00 a.m. BS=157, 2 units should have been given, 11/4/11 4:30 a.m. BS=146, 2 units should have been given, 11/6/11 4:00 a.m. BS=169, 2 units should have been given, 11/6/11 4:00 p.m. BS=245, 4 units should have been given, 11/7/11 4:00 p.m. BS=205, 4 units should have been given, 11/11/11 5:00 a.m. BS=146, 2 units should have been given, 11/11/11 4:00 p.m. BS=140, 2 units should have been given, 11/12/11 5:00 p.m. BS=240, 4 units should have been given, 11/15/11 4:00 p.m. BS=200, 2 units should have been given, 11/17/11 4:00 p.m. BS=289, 6 units should have been given, 11/19/11 5:00 a.m. BS=249, 4 units should have been given, 11/22/11 4:00 p.m. BS=242, 4 units should have been given,</p>		<p>scale orders for insulin administration and documentation of insulin coverage provided.</p> <p>Monitoring: DNS or designee will monitor the MAR on all shifts five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure proper insulin coverage and documentation is obtained. DNS or designee will review audits for trends and patterns. Any concerns will be taken to QAA for review.</p> <p>Date of Completion: December 31. 2011</p>		

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F0323 SS=D	<p>11/23/11 5:00 p.m. BS=155, 2 units should have been given, 11/25/11 5:00 a.m. BS=258, 6 units should have been given.</p> <p>On a diabetes care plan dated 4/26/11, an intervention indicated that medications are to be administered as ordered.</p> <p>In an interview with the DoN (Director of Nursing) on 12/1/11 at 9:00 a.m., she was unable to determine if Novolog coverage was given for the above blood sugars needing insulin coverage. Her expectation is that nursing follow physician's orders.</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to prevent falls for 1 of 2 residents reviewed for falls in a sample of 18 residents. Resident #27.</p> <p>Findings Include:</p> <p>The clinical record for Resident #27 was reviewed on 11/30/11 at 12:20 p.m.</p>	F0323	F323Corrective action: Resident #27 no longer resides at the facility. Matching set of bolsters were immediately applied on the day of incident. The Hospice company was notified of the bolster discrepancy. Other residents affected: No other resident was identified as being affected by the alleged deficient practice. Systemic changes: Facility-wide audit completed to	12/31/2011	

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	<p>Diagnoses for Resident #27 include, but are not limited to, alcohol induced persisting dementia (an alteration in reasonable thinking brought on by alcoholism), insomnia(difficulty sleeping), bipolar disorder (a mental health condition), epilepsy (a brain disorder that causes multiple seizures) and recent hospice placement (special care services for persons who are near the end of life).</p> <p>A facility fall investigation report was reviewed on 12/1/11 at 11:00 a.m. The report indicated Resident #27 had a fall on 11/18/11. The report indicated the fall was do to a mis-matched set of bolsters (an object that has 2 round sides connected by velcro straps placed under a mattress or sheets to keep residents from rolling out of their beds).</p> <p>During an interview with the D.O.N. (Director of Nursing) on 12/1/11 at 4:00 p.m. she indicated the hospice company providing services to Resident #27 placed the bolsters on the residents bed and they were not a properly matched set. She then indicated the facility was not aware of the mis-match because the straps to the bolsters are under the sheets and couldn't be seen. She indicated the resident leaned on the bolster, the bolster slid and Resident #27 fell to the floor. She also</p>		<p>ensure no other residents were affected by this deficient practice. An in-service was completed to re-educate licensed and certified staff on proper bolster set appearance and placement. Monitoring: DNS or designee will observe bolster placement on all shifts five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter. DNS or designee will review audits for trends and patterns. Any concerns will be taken to QAA for review. Date of completion: December 31, 2011</p>				

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	<p>indicated once the facility was aware of the mis-matched bolsters, the facility then replaced the bolsters and not the hospice company.</p> <p>A facility policy in regards to falls was requested on 12/1/11 at 2:30 p.m. The D.O.N. indicated she didn't believe the facility had a fall policy. As of final exit 12/1/11, no policy in regards to falls was provided.</p> <p>3.1-45(a)</p>				

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control professional practices were followed after urinary</p>	F0441	F441 Corrective action: PT #3 was immediately re-educated on proper glove and hand hygiene after care is given. C.N.A. #2 was immediately re-educated on	12/31/2011

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	<p>catheter/perineal care and wound care for 1 of 1 residents, reviewed for urinary catheter/perineal care and wound care, in a total sample of 18. (Resident #31)</p> <p>Findings include: During an observation after wound care/dressing change was performed by PT #3 for Resident #31, on 11/30/11 at 11:40 a.m., PT #3 did not remove her gloves and perform hand hygiene before she touched the resident's bed linens, resident's call light, and heater controls.</p> <p>In a policy for dressing changes received on 12/1/11 at 1:30 p.m., the policy indicated once the dressings are applied and secured with tape, "Remove gloves...assist resident to comfortable position with call light within reach."</p> <p>During an observation after catheter/perineum care was performed on Resident #31 by CNA #2 on 11/30/11 at 4:00 p.m., CNA #2 did not remove her gloves and perform hand hygiene before she touched Resident #31's gown and bed linens.</p> <p>In a policy for catheter care received on 12/1/11 at 1:30 p.m., the policy indicated once care was performed, "remove gloves....position resident comfortably with call light within reach."</p>		<p>proper glove and hand hygiene after catheter care is provided. Resident #31 was not adversely affected by the alleged deficient practice.</p> <p>Other residents affected: No other resident was identified as being affected by the alleged deficient practice.</p> <p>Systemic changes: An in-service has been held to re-educate licensed and certified staff to include therapy, nursing, and aides on appropriate glove and hand hygiene after patient care is given.</p> <p>Monitoring: DNS or designee will observe wound care and catheter/perineum care on all shifts five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter. DNS or designee will review audits for trends and patterns. Any concerns will be taken to QAA for review. This procedure will continue to be included in new hire orientation and at annual skills validation.</p> <p>Date of Completion: December 31, 2011</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2011

FORM APPROVED

OMB NO. 0938-0391

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	In an interview with the DoN (Director of Nursing) on 11/30/11 at 5:30 p.m., she indicated that once patient care was completed, the expectation was to remove the used gloves. 3.1-18(l)				