

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 04/03/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 24, 25, 26, 27, 28, 31, April 1, 2 & 3, 2014.</p> <p>Facility number: 000063 Provider number: 155138 AIM number: 100266210</p> <p>Survey team: Marcy Smith, RN-TC Patti Allen, SW Dottie Plummer, RN (March 31, April 1, 2 & 3, 2014) Karyn Homan, RN (March 31, April 1, 2 & 3, 2014)</p> <p>Census bed type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 12 Medicaid: 62 Other: 12 Total: 86</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 07, 2014; by Kimberly Perigo, RN.</p>	F000000		
F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>			

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>persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a dialysis shunt was monitored for signs and symptoms of infection (Resident #30), a physician was notified of frequent medication refusals (Resident #67), a laboratory blood test was drawn as ordered (Resident #37), and daily weights were measured (Resident #64) according to the residents' plans of care for 4 of 29 residents who met the criteria for review of care plans.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #30 was reviewed on 4/2/14 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease and depression.</p> <p>Resident #30 received dialysis (a process of filtering accumulated waste products using a kidney machine) weekly on Monday, Wednesday and Friday. He had an arteriole-venous fistula in his right forearm. A fistula is a surgically created connection and access site between a vein and an artery, which is used for dialysis.</p> <p>A care plan, created 1/27/14, indicated a problem of, "Alteration in Kidney Function due to chronic Renal disease...Related to ...Risk for infection related to fistula site..." Interventions included, "...Check access site</p>	F000282	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R30 had an order to check his fistula site for signs and symptoms of infection daily added to his orders.</p> <p>R67 Medical Director was contacted regarding the residents refusal of medications and stated they were aware of his often refusal. Order added to MAR for nurse to document MD notification of medication refusal.</p> <p>R37 had lab drawn 4/1/14 and the results were 6.0 which is within normal limits.</p> <p>R64 daily weights were changed to weekly.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All other residents that have orders for dialysis had medical records reviewed to ensure there were orders to check</p>	04/24/2014

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	<p>daily fistula...-signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills)..."</p> <p>A facility policy, titled, "Dialysis Guideline," dated January, 2011, received from the Director of Nursing on 4/1/14 at 10:30 a.m., indicated, "Documentation on Treatment Sheets Includes: Fistula checks daily:...Checks for signs/symptoms of Infection daily..."</p> <p>Treatment Administration Records and nurses' notes for March, 2014, did not indicate Resident #30's fistula site was ever checked for signs and symptoms of infection.</p> <p>During an interview with the Assistant Director of Nursing on 4/2/14 at 3:35 p.m., she indicated she was not able to find anything in Resident #30's record which indicated nurses were checking daily for signs and symptoms of infection at the fistula site.</p> <p>2. The clinical record of Resident #67 was reviewed on 4/1/14 at 3:43 p.m. Diagnoses for the resident included, but were not limited to, chronic bronchitis, urinary obstruction, peripheral neuropathy, heart disease, chronic kidney disease, dementia, high blood pressure, constipation and benign prostatic hypertrophy causing urinary obstruction.</p> <p>A care plan for Resident #67, dated 3/12/14, indicated a problem of, "I sometimes have behaviors which include ... refusing medications..." Interventions included, "...Give me my medications as my doctor has ordered...Let my physician know if my behaviors are interfering with my daily living..." These interventions originated</p>		<p>fistula site daily for signs and symptoms of infection,</p> <p>Residents medications were reviewed to ensure that any resident refused his medication had proper notification.</p> <p>Complete lab audit was conducted to ensure all labs were drawn any discrepancies were drawn immediately.</p> <p>Residents on daily/weekly weights were reviewed to ensure that weights were done and recorded.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recure are as follows:</p> <p>All new admissions and readmissions' medical records will come to the Clinical Start Up meeting to be reviewed to ensure that orders and weights are appropriate. During the daily Clinical Start Up meeting the nurses' documentation is reviewed as well as medication refusal to ensure notification of MD was done.</p> <p>Lab log has been initiated to</p>	

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	<p>6/7/12.</p> <p>Physician's orders, dated 2/27/14, indicated Resident #67 was to receive amiodarone 100 mg. (milligrams) daily for high blood pressure, clopidogrel 75 mg. daily for high blood pressure, isosorbide 30 mg. daily for high blood pressure, and aspirin 81 mg. daily for heart disease. Review of a Medication Administration Record (MAR) for March indicated he refused these medications on March 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 31, 2014.</p> <p>A physician's order, dated 2/27/14, indicated Resident #67 was to receive carvedilol 25 mg. 2 times per day for high blood pressure. The March, 2014, MAR indicated he refused this medication in the morning on March 2-11, 13, 15-28, and 31, 2014. He refused the medication in the evening on March 1, 2, 4, 5, 6, 8, 9, 10, 12-16, 18, 19, 23-31, 2014.</p> <p>A physician's order, dated 2/28/14, indicated Resident #67 was to receive tamsulosin 0.4 mg. every evening for benign prostatic hypertrophy. The March, 2014, MAR indicated he refused this medication on March 1, 2, 4-6, 8-10, 12-16, 18, 23-31, 2014.</p> <p>A physician order, dated 2/28/14, indicated Resident #67 was to receive gabapentin 100 mg. 2 times per day for peripheral neuropathy. The March, 2014, MAR indicated he refused this medication every morning on March 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 31, 2014.</p> <p>A physician order, dated 2/28/14, indicated</p>		<p>ensure scheduled lab draws are done. New lab orders will be reviewed in Clinical Stand Up as well as the lab log.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will report findings of Clinical Start Up Meetings to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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	<p>Resident #67 was to receive lubiprostone 24 micrograms 2 times per day for constipation. The March, 2014 MAR indicated he refused this medication in the morning on March 4-11, 13, 15-28, and 31, 2014. He refused the medication in the evening on March 1, 2, 4, 5, 6, 8, 9, 10, 12-16, 18, 22-31, 2014.</p> <p>Physician progress notes and nurses's notes for March, 2014, did not indicate Resident #67's medical physician or nurse practitioner were aware he was frequently refusing his medications.</p> <p>During an interview with the Assistant Director of Nursing on 4/2/14 at 11:00 a.m., she indicated she was unable to find any documentation which indicated the physician or nurse practitioner were aware he was refusing his medications.</p> <p>3. The clinical record of Resident #37 was reviewed on 3/31/14 at 1:36 p.m. diagnoses for the resident included, but were not limited to, diabetes mellitus and depressive disorder.</p> <p>A physician's order, dated 7/14/12, indicated Resident #37 was to have a HGBA1C laboratory blood test drawn every 6 months. This test measures the resident's average blood sugar level over the previous 3 months.</p> <p>Results of this blood test from January, 2013, were found in the resident's record. No other results were found.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 4/1/14 at 10:30 a.m., she indicated Resident #37 had refused to have the blood test drawn on July 18, 2013. She indicated she could not find where any other attempts were made to</p>			

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	<p>obtain the laboratory specimen after the resident's initial refusal on July 18, 2013.</p> <p>The next scheduled HGBA1C lab draw was January, 2014. The ADON indicated it was scheduled to be drawn by the lab on 1/6/14, but due to inclement weather, lab was not able to obtain any specimens for 3 days. The ADON indicated the lab had told her that because the blood was not drawn within 3 days of the scheduled draw, the "order dropped off their computer, and was missed." She indicated no one at the facility was aware the lab had not been drawn as ordered. She indicated the the lab had been notified and the HGBA1C would be drawn on 4/1/14.</p> <p>4. Resident #64's clinical record was reviewed on 4/1/14 at 2:00 p.m., and 4/3/14 at 12:00 p.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.</p> <p>A physician's order, dated 8/27/13, indicated weigh every day call if over 3 pounds lbs gain in 1 day or 5 lbs. in 1 week related to the congestive heart failure (CHF).</p> <p>Resident #64's record did not indicate weights were taken on the following days: 9/4, 9/5, 9/6, 9/8, 9/9, 9/11, 9/13, 9/14, 9/15, 9/16, 9/18, 9/20, 9/21, 9/23, 9/25, 9/30, 10/1, 10/2, 10/8, 10/10, 10/24, 10/25, 10/26, 10/27, 10/28, 10/30, 10/31, 11/2, 11/7, 11/8, 11/9, 11/11, 11/14, 11/16, 11/17, 11/18, 11/21, 11/22, 11/24, 11/26, 11/27, 11/28, 11/30, 12/1, 12/3, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16, 12/21, 12/25, 2013</p> <p>A physician's order dated 01/05/14 indicated</p>			

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F000371 SS=E	<p>a weekly weight was to be done every day shift, on Sundays. (CHF)</p> <p>The missed dates for weekly weights for February and March of 2014 were as follows:</p> <p>week of 2/23/14-3/1/14</p> <p>A physician's order dated 03/04/14 indicated, weight daily call if over 3 lbs/day or 5 lbs/week. (CHF)</p> <p>The missed dates for daily weights for March, 2014 were as follows: 3/5, 3/6, 3/8, 3/11, 3/12, 3/13, 3/14, 3/24, 3/27, 3/28, 3/29, 3/30, 3/31, 2014.</p> <p>Total missed 67/162</p> <p>Further information was requested on 4/3/14, from the ADNS (Assistant Director of Nursing Services) in regard to daily weight monitoring as indicated in the physician's order.</p> <p>During an interview with the ADNS on 4/3/14 at 2:00 p.m., she indicated the facility did not have any further information in regard to weight monitoring for #64.</p> <p>3.1-35(g)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the</p>	F000371	F371 The facility will store, prepare, distribute and serve food under sanitary conditions. 1)				

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	<p>facility failed to ensure food was prepared under sanitary conditions for 1 of 1 kitchens reviewed. This had the potential to effect 85 of 86 residents who were served meals from the kitchen.</p> <p>Findings include:</p> <p>During the preparation of the noon meal on 04-01-14 at 11:00 a.m., with the Dietary Manager, the following were observed:</p> <p>1) Dietary Staff #1 was observed near the steam table preparing salads for the noon meal under a cabinet with peeling, chipped and loose paint. The same staff member was observed a few minutes later near the large mixer cutting up fruit and placing it in a bowl for the noon meal, under a cabinet with peeling, chipped and loose paint.</p> <p>2) The large mixer had multiple colored stains and chipped, peeling and loose paint above the mixing bowl.</p> <p>3) In the bin where apples were stored, there were three (3) of twenty-seven (27) apples that had turned brown and had a grayish fuzzy substance on them.</p> <p>4)The hood above the stove had chipped, peeling, and loose paint above the burners.</p> <p>5) Dietary staff # 2 was observed to handle the cornbread with gloved hands after she had handled the serving trays, the plates, wiped the counter, and handled plate covers for the room trays.</p> <p>On 04/01/14, at 1:10 p.m., during an interview with the Dietary Manager, she verified with the observations indicated</p>		<p>The cabinets near the steam table and mixer, the mixer, and the hood above the stove area were painted the evening of April 1, 2014. 2) On April 1, 2014 the 3 spoiled apples were discarded and not served to any residents. 3) Dietary Staff # 2 was immediately educated on proper glove use and handling of foods during meal service on 4/1/14. 4) All dietary staff were in-serviced and educated on food storage, reporting maintenance issues, food handling and glove use on 4/24/14 5) Meal service monitoring tool implemented on April 21, 2014 on the deficient areas and to be completed 7 days a week; one meal per day by the in-house RD or DM for four weeks, three days per week for an additional four weeks and then 1 day weekly for an additional four weeks (total 12 weeks monitoring). 6) Any deficient areas will be reported in QAPI on a monthly basis or ad hoc if warranted for recommendations and resolutions.</p>	

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F000441 SS=E	<p>above.</p> <p>3.1-21(i)(3) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>			
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	<p>of infection.</p> <p>Based on observation and interview, the facility failed to store soiled linen in a sanitary manner in 1 of 2 soiled utility rooms and failed to handle personal linens in a sanitary manner, which had the potential to affect 78 of 86 residents whose laundry was cleaned within the facility. Findings include: 1) During observation of Hall A on 4/1/14 at 12:25 p.m., a strong odor of stale urine was noted in the hallway housing rooms 2-10 and the hallway housing rooms 11-18. The odor was stronger near the room marked soiled utility. The Director of Nursing (DoN) was present, and indicated the odor was most likely due to the storage of the soiled linen and trash carts in the utility room, as it was lunchtime, and the carts were stored in that room during mealtimes. The DoN opened the door to the utility room, and a strong pungent odor permeated the utility room, and wafted into the hallway. The entryway of the room was partially blocked by a 3 bin cart, identified by the DoN as 1 of 2 soiled linen carts utilized on Hall A. A second cart was noted further into the room. The second cart had lids missing on 2 of the 3 bins. The first bin contained a clear bag of white linen. The second bin was empty, and the third bin had a clear bag sitting on top of the lid. A brown substance was noted on the contents of the clear bag. An accumulation of a brown substance, dust/dirt, debris, and dried fluid was noted on the interior and exterior structure of the carts, wheels, and lids. The bags hanging in the bins were torn, and were splattered with brown spots. The DoN indicated the clear bag located on the top of the cart was most likely the cause of the</p>	F000441	<p>1. Corrective actions for deficiencies found under F 441 sec. 1 are as follows: a. The utility room floor has been Striped and waxed. April, 1 2014 b. Discarded and replaced all soiled linen trash carts with new carts. April 24, 2014 c. Removed all trash and linen from the floor. April 2, 2014 d. Removed all torn trash bags. April 1, 2014 e. The mattress was removed and discarded. April 2, 2014 f. Red biohazard totes were emptied and the lids were adjusted to their proper positions on those totes. April 2, 2014 g. All soiled bedpans, emesis basin, and urine collection containers were removed cleaned and or discarded. April 2, 2014 h. The mop bucket was cleaned and returned the janitors closet. April 2, 2014 i.. The broken sanitizing machine has been removed. April 24, 2014 j. The soiled IV pole has been cleaned. April 2, 2014 k. The open window has been closed. April 2, 2014 2. Corrective actions for deficiencies found under F 441 sec. 2. are as follows: a. Linen carts will be replaced with new carts that are self contained eliminating the need of a sheet to cover clean personal laundry as they are transported to the residents. April 24, 2014 b. Laundry staff will be in-serviced on the proper techniques of handling clean personal laundry so as to</p>	04/24/2014

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	<p>odor.</p> <p>A review of the soiled utility room revealed a large, open, clear bag on the floor, which contained soiled plastic emesis basins, soiled plastic bedpans, soiled washbasins, and soiled urine collection containers. The clear bag blocked the path to the sink located in the corner of the room. The sink contained a soiled bedpan. A large blue mattress with hoses and an inflated waffle mattress were noted on the floor. Large red totes were located in the back of the room, and the lid to 1 tote was slightly raised, with a clear bag visible near the top of the tote. An empty soiled mop bucket, mop and cart were located near the hopper (a large flushing sink/toilet with a sprayer). A sanitizing machine in the room had a note taped to the front indicating the machine was broken, and was not to be used. A soiled IV (intravenous) pole was noted in front of the machine. The window in the room was open approximately 1 inch. Cool air was felt in front of the window.</p> <p>On 4/2/14 at 11:30 a.m., during an observation of the soiled utility rooms with the Administrator, the pungent odor was noted in the utility room on Hall A, and wafted into the hallway when the door was opened. The Administrator indicated the smell was unidentifiable, but would be investigated. A large clear bag containing white material was noted on the floor next to a 3 bin cart. The contents of the room, including the large clear bag on the floor containing soiled equipment, were unchanged from observations on 4/1/14.</p> <p>2) During an observation of 2 laundry staff on 4/1/14 at 1:05 p.m., both staff members were observed touching clean personal laundry against uniform tops, and then placing the articles onto a hanging rack. Laundry staff</p>		<p>avoid securing clean personal laundry against their uniforms by April 24, 2014 After removal and cleaning of items listed in section 1, no odors have been observed originating from the soiled utility room on section A. In addition to addressing the concerns listed in this section the remaining soiled utility room on section B has also been inspected with no odors or infection control concerns identified. To ensure these deficient practices do not recur: Utility rooms on section A and B will be put on a daily environmental rounds schedule that will be conducted every business day by the executive director, nursing supervisor, the housekeeping supervisor, or designee to ensure cleaning concerns and infection control concerns are identified and addressed timely. Rounds will be initially implemented 7 days per week x 30 days, then 3 days weekly thereafter to ensure that housekeeping/infection control issues are identified and addressed immediately. In addition All staff will be in-serviced on infection control and proper use of the soiled utility rooms as well as reporting any infection control concerns to management. Housekeeping manager or designee will audit one shift 7 days per week x 30 days to ensure that clean personal laundry items are transported to residents properly.</p>	

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 04/03/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203
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	<p>member #1 indicated the laundry was washed and dried in the basement, and was then transported to the first floor via a dumbwaiter. The laundry was then transferred to the hanging rack for distribution to the residents. Laundry staff member #1 was observed as several hangers containing articles of clothing were removed from the rack in the dumbwaiter, secured against the uniform top, and then transferred to Laundry staff member #2. Laundry staff member #2 secured the articles of clothing against the uniform top, and then placed the hangers onto a hanging rack. The process was observed 3 times. Laundry staff member #1 indicated a white sheet folded loosely into the corner of the dumbwaiter was the clean sheet utilized to cover the laundry during transport to the residents.</p> <p>3.1-19(g)(1)</p>		<p>All Staff will to be in serviced on proper handling of clean personal laundry. Results of rounds and audits will be presented at QA&A for follow up x 3 months to track for trends. If any trends are identified rounds will continue based on QA&A recommendations. If no trending then will be reviewed on a prn basis.</p>	