

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 17, 18, 19, 20, 21, &amp; 24, 2011.</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Survey team: Christi Davidson, RN-TC Connie Landman, RN Diana Zgonc, RN Deborah Barth, RN (10/17, 10/18, 10/19, 10/20, 10/21, 2011)</p> <p>Census bed type: SNF/NF: 125 Total: 125</p> <p>Census payor type: Medicare: 14 Medicaid: 95 Other: 16 Total: 125</p> <p>Sample: Stage 2 sample 41</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>November 11, 2011 Golden Living Center - Brookview Provicer #155076 Recertification &amp; State Licensure Survey Plan of Correction Survey Dates: October 17, 18, 19, 20, 21, &amp; 24, 2011 Preparation, submission, and implementation of this 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. All corrections will be in place on November 23, 2011.</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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F0279 SS=D	<p>Quality review completed on October 28, 2011 by Bev Faulkner, RN</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to ensure care plans addressed current resident conditions and care needs for 3 of 28 residents reviewed for care plans in a Stage 2 Sample of 41 (Residents #96, #182, # 113).</p>	F0279	<b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Resident #'s 113, 182, and 96 have had their care plans reviewed and updated. <b>Other residents having the potential to be</b>	11/23/2011	

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	<p>Findings include:</p> <p>1. The record for Resident #113 was reviewed on 0/19/11 at 10:10 A.M.</p> <p>Current diagnoses included, but were not limited to, Alzheimer's Disease, acute mucoid otitis media, anxiety state, HTN (hypertension), depressive disorder, diabetes without complications, unspecified psychosis, senile psychotic condition, and esophageal reflux.</p> <p>The October, 2011, recapitulation of physician orders indicated the current treatment, ordered 8/29/11, was Santyl 250 unit/gm (gram) ointment - ischium - cleanse with wound cleanser and gauze, apply Santyl to wound bed, apply Calmoseptine to periwound, cover with Allevyn foam dressing. PT (Physical Therapy) to do 5x/week and nursing to do 2x/week and PRN (as needed). Another order, dated 8/17/11, indicated Flagyl 5000 mg (milligram) tablet was to be crushed and placed into the wound bed every day by PT. On 12/18/08, an order was written for a pressure reducing mattress on a low bed.</p>		<p><b>affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b>All care plans have been audited by the Nurse Management Team, for completeness. We are starting a new process of care plan meetings, for any resident returning from a hospitalization, and ensuring that the care plan is in place. They are called Care Management Meetings, which will include the interdisciplinary team. Unit Managers will be auditing the care plans of new admissions and re-admissions. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> Nursing staff have been in-serviced on immediate plans of care, (IPOC's). The Unit Managers/ RN Supervisor will audit the care plan of new admissions and re-admissions within 24 hours of admission. This auditing will be ongoing. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> Any resident, new admission or readmission will have the care plan reviewed by the Nurse Management team in our daily Clinical Start Up meeting. The DNS/designee will review the audit done by the Unit</p>		

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	<p>Observation of Resident #113 on 10/17/11 at 10:00 A.M., showed the resident to be in a low bed with a pressure reducing mattress in operation. The resident was positioned on her left side and appeared very comfortable, sleeping soundly. At 1:15 P.M., Resident #113 was being fed her lunch in bed positioned on her back. CNA #7 was speaking soothingly to the resident and encouraging her to eat.</p> <p>The CNA, at that time, indicated Resident #113 did not get out of bed anymore due to her daughter not wanting her to get up, just to stay in bed and be comfortable.</p> <p>On 10/18/11 at 9:45 A.M., the DON (Director of Nursing) indicated Resident #113's daughter did not want the resident gotten up anymore, and did not want the resident weighed. The DON indicated the resident used to be on hospice services but that ended, and the daughter does not want the resident re-admitted to a hospice service as she felt the facility could provide palliative end of life care just as well.</p> <p>The record, observation, and Wound Evaluation Flow Sheets indicated the</p>		Managers daily (5 days/week) X 2 months then weekly X 1 month. DNS will report any trends to QA&A on a monthly basis.		

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	<p>resident had an unstageable pressure ulcer to her right ischium, which measured 4.7 cm (centimeter) long, by 6.4 cm wide by 0.7 cm deep on 10/18/11.</p> <p>During the wound treatment observation on 10/19/11 at 11:10 A.M., LPN #9 indicated the nursing staff did the wound treatment daily, the daughter did not want PT to do the treatment or any extra measures.</p> <p>The record lacked a care plan for the current ischial pressure ulcer and its treatment. The care plan also lacked addressing daughter's desire (per staff) to keep the resident in bed, to not weigh her, and to have nursing, not PT do the ischial ulcer treatment.</p> <p>During an interview with the DON on 10/19/11 at 1:40 P.M.,she was informed a care plan addressing Resident #113's daughter's wishes for her care and wound treatment could not be found. At that time she indicated she was going to call the resident's daughter and get these things addressed. No further information was provided prior to the final exit conference on 10/24/11 at 11:30 A.M.</p> <p>2. The record for Resident # 182 was reviewed on 10/20/11 at 10:30 A.M.</p>				

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	<p>Diagnoses for Resident # 182 included but were not limited to abdominal pain, Diabetes, Hypertension, End Stage Renal Disease and Chronic Airway Obstruction.</p> <p>Resident was admitted to the facility on 10/13/11.</p> <p>A current physician's order, dated 10/17/11, indicated, check the dialysis shunt for Bruit and Thrill every shift. The resident receives dialysis on Tuesday, Thursday and Friday.</p> <p>The record lacked documentation of a care plan to check the dialysis shunt for Bruit and Thrill on every shift.</p> <p>During an interview with the Rehab/Sub-acute Unit Manager on 10/20/11 at 1:00 P.M., she indicated there were no care plans for the resident's dialysis or the care of the shunt.</p> <p>3. The record for Resident # 96 was reviewed on 10/19/11 at 1:35 P.M.</p> <p>The admission date for Resident # 96 was 5/28/10.</p> <p>Diagnoses for Resident # 96 included</p>			

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	<p>but were not limited to, Depressive Disorder, Anxiety state, Hypertension, Calculus of Kidney, Chronic Airway Obstruction, Lumbago, Diabetes, Chronic Ischemic Heart Disease, Paralytic Ileus, Dysphagia, feeding gastrostomy, Benign Prostatic Hypertrophy with obstruction, paraplegia, cancer and Coronary Atherosclerosis.</p> <p>During the initial interview with the resident on 10/18/11 at 9:35 A.M., it was observed that he had a contracture of his right hand and did not wear a splint.</p> <p>During an interview with the resident on 10/19/11 at 2:20 P.M., the resident indicated he did not like wearing the splint so he never puts it on; it stays in his drawer.</p> <p>During an interview with LPN #2 on 10/19/11 at 2:10 P.M., she indicated the resident doesn't wear the splint because he doesn't like it.</p> <p>Record review of therapy notes for August 2011 indicated the resident was seen by Occupational Therapy and the use of a splint to the right hand was recommended when the resident was up in the wheel chair. The resident may remove the splint if it becomes uncomfortable.</p>				

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	<p>During an interview 10/19/11 at 2:15 P.M., with the Therapy Director, she indicated it's case by case basis for determination of what type and other options are used when a resident refuses to wear a recommended splint. Sometimes we change the splint to something softer or the resident will wear it to bed instead of during the day, etc.</p> <p>The record for Resident # 96 lacked documentation of a care plan for the resident's contracture or for his refusal to wear the splint.</p> <p>During an interview with the Rehab/Sub-Acute Unit Manager on 3/19/11 at 12:30 P.M., she indicated there were no care plans for the resident's splint or the resident's refusal to wear it.</p> <p>3.1-35(a)</p>				

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F0280 SS=A	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure residents and/or family members were invited to attend care plan meetings for 1 of 28 residents reviewed for participation in care planning (Resident #72) in the Stage 2 sample of 41.</p> <p>Findings include:</p> <p>The record for Resident #72 was reviewed on 10/20/11 at 12:45 P.M.</p> <p>Current diagnoses included, but were not limited to, CHF (congestive heart</p>	F0280	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>Social Services Designee met with resident #72 on 10/20/11 and reviewed and updated care plan with resident #72.<b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> The Social Services Director will audit the care plan schedule to verify that the RN Assessment Coordinator has added newly admitted residents</p>	11/23/2011	

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	<p>failure), IDDM (insulin dependent diabetes mellitus), iron deficiency anemia, HTN (hypertension), esophageal reflux, chronic airway obstruction, and cardiac pacemaker.</p> <p>During an interview with Resident #72 on 10/17/11 at 2:15 P.M., he indicated he was not involved in decisions about his care, and he had not been invited to a care plan meeting.</p> <p>The record lacked documentation of Resident #72 being invited to or attending a care plan meeting.</p> <p>During an interview on 10/20/11 at 1:15 P.M., SS (Social Services) #6 indicated the IDT (interdisciplinary team) notes usually say who attended, and she would find out why no notes were in the record.</p> <p>During an interview with SS #6 on 10/20/11 at 2:45 P.M., she indicated the resident will be invited to the care plan meeting scheduled 11/18/11, but an initial care plan meeting did not appear to have been held, and she did not know why it wasn't.</p> <p>During an interview with the DON (Director of Nursing) on 10/21/11 at 9:00 A.M., she indicated every once</p>		<p>to the care plan schedule. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The care plan schedule established by the RN Assessment Coordinator will be audited by the Social Services Director to verify that newly admitted residents are added to the care plan schedule. The audit will be done weekly X 4 weeks, then monthly ongoing.</p>		

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F0314 SS=D	<p>in a while a care plan meeting slips through the cracks and unfortunately it appears this is what happened.</p> <p>3.1-35(c)(2)(C)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure ulcer treatments were done appropriately for 1 of 3 residents reviewed for pressure ulcer treatments in a Stage 2 Sample of 41 (Resident #113)</p> <p>Findings include:</p> <p>Resident #113's record was reviewed on 10/19/11 10:10 A.M.</p> <p>Current diagnoses included, but were not limited to, Alzheimer's Disease,</p>	F0314	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>Resident # 113's treatment order was clarified with the Wound Care Physician. <b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b>Residents having the potential to be affected, all orders have been reviewed and clarified if necessary for complete and clear directions for how to do the</p>	11/23/2011	

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	<p>acute mucoid otitis media, anxiety state, HTN (hypertension), depressive disorder, diabetes without complications, unspecified psychosis, senile psychotic condition, and esophageal reflux.</p> <p>The October, 2011, recapitulation of physician's orders indicated the current treatment, ordered 8/29/22, was Santyl 250 unit/gm (gram) ointment - to the right ischium - cleanse with wound cleanser and gauze, apply Santyl to wound bed, apply Calmoseptine to periwound, cover with Allevyn foam dressing. PT (Physical Therapy) to do 5x/week and nursing to do 2x/week and PRN (as needed). Another order, dated 8/17/11, indicated a Flagyl 5000 mg (milligram) tablet was to be crushed and placed into the wound bed every day by PT. On 12/18/08, an order was written for a pressure reducing mattress on a low bed.</p> <p>On 10/19/11 at 11:10 A.M., the dressing change was done by LPN #9. Supplies were prepared and at the bedside. The Flagyl was crushed and on top of the Santyl in a plastic medicine cup. The area was cleansed with spray wound cleanser, and wiped with a gauze square. A tongue depressor was taken out of its</p>		<p>treatment. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> Licensed staff have been inserviced on the proper way to enter a treatment order with step by step instructions per the physician. The Nurse Management team will audit all treatment orders during Clinical Start-Up on a daily basis for proper transcription of the order and precise instructions. This auditing will be ongoing. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The DNS/ designee will be a participant in the Clinical Start-Up. Any patterns will be brought before the QA&amp;A committee on a monthly basis.</p>		

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	<p>wrapper and used to mix the Flagyl with the Santyl. The mixture was then applied to the wound bed. The medicine cup was thrown away. During an interview with LPN #9 at that time, she indicated "most of it (the mixture) was used, only a little bit" was left in the cup as it was being thrown away. An Allevyn dressing was applied. At that time, LPN #9 indicated PT does not do the wound treatment per the daughter's request as she does not want any "extra measures" taken.</p> <p>During an interview with the DON (Director of Nursing) on 10/19/11 at 2:00 P.M., she indicated the Santyl should have been a measured amount, and all of it should have been used, and also indicated the physician's order did not clarify the Flagyl could be mixed with the Santyl instead of being placed in the wound bed.</p> <p>3.1-40(a)(2)</p>				

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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure an indication for use was established prior to starting a resident on an anti-anxiety medication and failed to ensure a tapering of the medication was implemented (Resident #171). In addition, the facility failed to ensure monitoring of blood pressure and pulse prior to administration of a blood pressure medication with specified parameters for use (Resident #7). This affected 2 of 10 residents reviewed for unnecessary drugs from the stage 2 sample of 41.</p>	F0329	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>Resident # 7's order was clarified and re-entered into the E-MAR on 10/20/11. Resident # 171 had a gradual dose reduction ordered by the physician on10/20/11.<b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b>All orders have been audited for proper entry for the parameters that the MD has set forth for safe administration of</p>	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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	<p>Findings include:</p> <p>1. The record for Resident #7 was reviewed on 10/19/11 at 1:36 p.m.</p> <p>Diagnoses included, but were not limited to congestive heart failure, anxiety, psychosis, diabetes, hypertension, osteoarthritis, macular degeneration of retina, obesity and depressive disorder.</p> <p>A recapitulation for Resident #7, dated for October 2011 with an original physician's order dated 05/16/11, indicated, "...Metoprolol Tartrate [antihypertensive, antianginal] (25 mg) [25 milligrams]...Tablet By mouth - Two times a day Everyday...Hold for SBP [systolic blood pressure] &lt; [less than]100 or HR [heart rate] &lt; [less than] 55...."</p> <p>During an interview on 10/20/11 at 9:00 a.m., the Director of Nursing (DoN) indicated blood pressures and heart rates would be recorded on the Medication Administration Record (MAR) if the medication was ordered with specific hold parameters. A copy of Resident #7's October MAR was requested at this time.</p>		<p>certain medications. All residents with orders for Psychotropic Drugs will be reviewed by the Interdisciplinary team to ensure gradual dose reduction is addressed by MD. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b>Licensed staff have been inserviced on the proper order entry into E-MAR enabling the parameters to be documented on the MAR, and gradual dose reduction. The Interdisciplinary team will review the psychotropic drugs and possible dose reduction during the Care Plan meeting and discuss and document any concerns. The Interdisciplinary team will discuss any concerns during the Clinical Start-Up meeting, 5 days weekly. This will be ongoing. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b>DNS or designee will review the care plan meeting notes to ensure the proper management of gradual dose reduction has been reviewed. Any patterns will be brought before the QA&amp;A committee on a monthly basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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	<p>A copy of the October MAR for Resident #7 was provided by the DoN on 10/20/11 at 9:42 a.m.</p> <p>The MAR for Resident #7 for October 2011 indicated Metoprolol Tartrate 25 mg was given daily at 9:00 a.m. and 9:00 p.m. for October 1, 2011 through October 19, 2011. The MAR lacked documentation of blood pressure and heart rate recordings for each dose marked as given.</p> <p>During an interview on 10/20/11 at 9:45 a.m., the DoN indicated the order had not been properly entered into the electronic system; therefore it did not cue the nurse to record the blood pressures or heart rates. The DoN indicated if the order was properly entered the medication nurse could not move forward in the system until the information for the parameters was entered.</p> <p>2. Resident #171's record was reviewed on 10/20/22 at 8:50 A.M.</p> <p>Current diagnoses included, but were not limited to, CHF (congestive heart failure), HTN (hypertension), hyperlipidemia, osteoarthritis, dementia, anxiety state, and urinary incontinence.</p>			
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	<p>During a medication administration observation on 10/19/11 at 9:10 A.M., Resident #171 was observed sitting on the side of her bed. She was very pleasant and spoke to the medication nurse in a calm, friendly, and happy tone. She took her medication and remained very pleasant and joking during the interaction.</p> <p>The current recapitulation of physician's orders indicated Lorazepam 0.5 mg (milligrams) was to be given every day - hold for sedation, originally ordered on 7/16/11. No other order concerning Lorazepam was found. Lorazepam 0.5 mg was administered with Resident #171's other morning medications.</p> <p>Review of the Nursing Progress Notes lacked documentation of any anxiety or anxious episodes.</p> <p>A Social Services Progress Note, dated 7/11/11, indicated "... She denies depression or anxiety. Noted to receive lorazepam however resident denies have symptoms of anxiety. Per staff interview no observed signs of anxiety. Will continue to observe...."</p> <p>A care plan, dated 7/14/11,</p>			

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	<p>addressed the use of psychotropic medications related to use of anti-anxiety medication. One intervention is to refer to psychologist/psychiatrist for medication and behavior intervention recommendations. The Social Services Progress Note, dated 7/11/11, indicated Resident #171 was offered psychiatric/psychological services but declined.</p> <p>The Clinical Pharmacist Medication Regimen Review indicated the resident's medications had been reviewed on 8/9/11 and 9/15/11. The reviews lacked a recommendation for decrease of the Lorazepam since the resident was not displaying symptoms of anxiety.</p> <p>During an interview with SS #6 on 10/20/11 at 10:30 A.M., she indicated she was unaware of the resident being anxious, and did not know why a gradual drug reduction had not been initiated.</p> <p>A current facility policy, dated 1/11, titled "Behavior Management Guideline", provided by the DON (Director of Nursing) on 10/21/11 at 9:00 A.M., indicated: "... Antipsychotic Medication... ...Each resident's drug regimen will be</p>				

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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F0406 SS=D	<p>free from unnecessary drugs. An unnecessary drug is any drug when used:...</p> <p>Without adequate indications for its use..."</p> <p>3.1-48(b)(1)2.</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to follow the recommendations made on the developmental evaluation plan for 1 of 41 residents reviewed in Stage 2 sample of 41. (#53)</p> <p>Findings include:</p>	F0406	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>Resident # 53's care plan has been reviewed and revised as needed.</p> <p><b>Other residents having the potential to be affected by the same deficient practice will be</b></p>	11/23/2011	

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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	<p>The clinical record for Resident # 53 was reviewed on 10/20/11 at 11:45 a.m. The resident had diagnoses which included, but were not limited to: paraplegia, dysphasia, accidental fall, hypothyroidism, and mental retardation.</p> <p>The Preadmission Screening Assessment, dated 4/29/11, indicated the resident was developmentally disabled, required a resident review each year, and medical needs took precedence over other service needs at the time.</p> <p>The Interdisciplinary Developmental and Evaluation Center (IDEC) assessment was dated 4/25/11. The following recommendations were made on the assessment: the resident would benefit from residential setting to provide 24 hours supervision, may benefit from access to Physical Therapy, Occupational Therapy, and Speech Therapy services, may benefit from close follow along by primary care physician with regular laboratory testing, routine vision, hearing, dental, &amp; podiatry, may benefit from monitoring for cognitive changes or signs/symptoms of anxiety or depression with no history of the same, may benefit from</p>		<p><b>identified and the corrective actions taken are as follows:</b>An audit was done on all residents with the diagnosis of Mental Retardation. The IDEC assessment was reviewed for any other specialized rehabilitative services. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> Licensed staff and Social Services have been educated on the Level 2 assessment and the specialized rehabilitative services. Upon admission of a 4th MR resident the facility would implement a program related specifically to the care of those residents. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The DNS/ designee will review this process to ensure that these residents have appropriate care plans and ensure that we follow the IDEC plan as appropriate . Any patterns will be brought before the QA&amp;A committee on a monthly basis.</p>		

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provision of tv, music, or other stimuli of interest and participate in activities, and needs continued guardianship.</p> <p>The care plan had been reviewed on 9/2/11. There was no indication of coordination of the recommendations made by the IDEC plan. The social service progress notes were reviewed with no indication of any coordination of the recommendations from the IDEC plan.</p> <p>The Director of Nursing was interviewed on 10/20/11 at 2:00 p.m. She indicated an activity assistant had been trained to become the Qualified Mental Retardation Professional Designee (QMRPD).</p> <p>There were no progress notes from the QMRPD on the clinical record, nor were any presented.</p> <p>3.1-23(a)(1)</p>				

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>A. Based on record review and interview, the facility failed to have medications available for 1 of 10 residents reviewed for pharmacy services in the Stage 2 sample of 41. (#48)</p> <p>B. Based on record review, interview and observation, the facility failed to ensure the medication carts were free of expired medications for 1 of 6 carts checked for expired medications</p> <p>Findings include:</p> <p>A.1. The clinical record for Resident # 48 was reviewed on 10/19/11 at 10 a.m. The resident had diagnoses</p>	F0425	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>Resident # 48 has been receiving her medications as ordered per MD. The medication carts do not have any expired medications. <b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b>A facility wide audit was done on all residents to ensure medications are available and being given per MD order. All medication carts were audited for expired medications. <b>The measures put into place and the systemic changes made to ensure that</b></p>	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2011	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219			
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	<p>which included, but were not limited to: lung cancer, chronic obstructive lung disease, and anxiety.</p> <p>The care plan, dated 9/13/11, indicated pain management was a problem with interventions that included administer pain medications as ordered, evaluate and establish level of pain on numeric scale tool, evaluate characteristics and frequency /pattern of pain, evaluate need for routinely scheduled medications rather than prn (upon request) pain med administration, evaluate need to provide medications prior to treatment or therapy, evaluate what makes the pain worse, implement the preferred non-pharmacological pain relief strategies, and utilize pain monitoring tool to evaluate effectiveness of interventions.</p> <p>The physician admitting orders, dated 9/5/11, had included soma (a muscle relaxant) 350 milligrams (mg) q 6h (every six hours). The Medication Administration Record (MAR) indicated the medication had not been given from 9/5/11 until 9/8/11 at 7:15 p.m. There was an entry on the MAR at the bottom of the page that indicated the pharmacy was called on</p>		<p><b>this deficient practice does not recur are as follows:</b>Licensed staff have been inserviced on the procedure to be taken if a medication is not available within reasonable time, and expiration time frames of medications and procedure to be followed. Unit managers /designee will monitor the resident record within 24 hours of admission / re-admission and verify that all medications are available for administration. This process will be monitored 7 days a week for residents for all admissions / re-admissions. Unit managers will also audit the medication carts 3 times weekly X 1 month, then 2 times weekly X 1 month, then 1 time weekly. These processes will be ongoing. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b>The DNS/ designee will review this process to ensure that the records are reviewed timely and medications are available and that the medication carts are free of expired medications.. Any patterns will be brought before the QA&amp;A committee on a monthly basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2011
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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	<p>9/6/11. The medication was not available in the 350 mg strength and the order was clarified to the 250 mg strength to be given q 6h.</p> <p>The review of the MAR for September, 2011 also indicated the resident was to have received Percocet 5/325 q 6h daily while awake. Review of the physician orders indicated the pain medication order had been changed on 9/11/11. The MAR indicated the medication was not available and so was not given on 9/13/11, 9/14/11, and 9/15/11. An entry on the bottom of the MAR indicated the pharmacy and physician were notified on 9/13/11.</p> <p>Interview with the Director of Nursing, on 10/21/11 at 10:30 a.m., indicated she had not been aware of the medication not being given, but it should have been given from the EDK (emergency drug kit).</p> <p>B. 2. During observation of the medication carts on 10/19/11 at 9:25 A.M., the following medications were expired:</p> <p>West Hall Medication Cart Lantus Insulin, opened 8/16/11 Xalatan Eye Drops, opened 6/3/11</p>			

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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	<p>During an interview with LPN # 1 on 10/19/11 at 9:25 A.M., she indicated, I think insulin expires in 21 days.</p> <p>A current manufacturer insert for Lantus Insulin indicated an open bottle of Lantus, refrigerated or at room temperature, should be used for 28 days and then disposed of.</p> <p>A current manufacturer insert for Xalatan (Latanoprost Ophthalmic Solution) eye drops may be stored at room after opening for 6 weeks and then disposed of.</p> <p>3.1-25(g)(2) 3.1-25(j)</p>				

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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F0431 SS=D	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and record review, the facility failed to include date opened labels on medications with expiration dates dependent on date opened as observed on 2 of 6 medication carts checked for expired medications.</p>	F0431	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b>All medication carts have been audited for date open labels. <b>Other residents having the potential to be affected by the same deficient practice will be</b></p>	11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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	<p>Findings include:</p> <p>During observation of medication carts on 10/19/11 at 9:25 a.m., the following medications did not have date opened labels:</p> <p>Sub-Acute Medication Cart 1- Lantus Insulin, no open date.</p> <p>Dementia Unit Medication Cart 1-Lumigan eye drops, no open date.</p> <p>A current manufacturer insert for Lantus Insulin indicated an open bottle of Lantus, refrigerated or at room temperature, should be used for 28 days and then disposed.</p> <p>3.1-25(o)</p>		<p><b>identified and the corrective actions taken are as follows:</b>An audit was done on all medication carts. Date open labels are in place. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> Licensed staff have been inserviced on date open labels and the importance of the label in relation to the expiration of those medications. Unit Managers/ designee will monitor the medication carts 3 X weekly X 1 month, then 2 times weekly X 1 month, then 1 X weekly ongoing. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The DNS/ designee will review this process to ensure that the medication cart audits are done timely as set forth above and randomly audit a cart to ensure accuracy. Any patterns will be brought before the QA&amp;A committee on a monthly basis.</p>	
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 and record review, the facility failed to assure 1 of 4 licensed nursing staff washed their hands while passing medications to 3 of 17 residents. (Resident # 30, 66, &amp;</p>	F0441	<b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Residents numbered 30,	11/23/2011

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176)	<p>Findings include:</p> <p>The medication pass was observed on 10/20/11 from 8:30 to 9:00 a.m. LPN # 1 failed to wash her hands between residents. She proceeded to pass medications to Resident # 30 first without washing her hands before preparing the medications or after giving them to the resident. She then proceeded to set up and give the medications to Resident # 66. While passing medications to Resident # 66, LPN # 1 touched the resident's bed as she got up and down from her knees to feed the resident the applesauce she had floated the medications in. She again proceeded to set up and pass the medications to Resident # 176 without washing her hands between the residents. She washed her hands after passing the medications to Resident # 176.</p> <p>The policy for handwashing was reviewed on 10/20/11 at 10:30 a.m. The policy was presented by the Director of Nursing The policy indicated the following: "...Hands should be thoroughly washed before and after providing resident care."</p>		<p>66, and 176 have been seen by the Physician/ NP and those residents are free of signs and symptoms of infection due to the LPN not washing her hands. LPN # 1 has been educated regarding the facility handwashing policy and the infection control policy. <b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b>All residents have the potential to be affected per this practice. Nurses will be monitored by Unit Managers for medication pass on 3 residents daily to ensure proper handwashing practice. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> Licensed staff have been inserviced on proper handwashing technique and the infection control policy. Unit Managers will audit 1 nurse on each shift X 5 days a week for 3 residents X 1 month, then 1 nurse on each shift 3 days a week for 2 residents X 2 weeks, then 1 nurse on any shift 3 days a week for 2 residents X 2 weeks, then 1 nurse 1 X weekly for 1 resident X 3 months.<b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The DNS/</p>		

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	Interview with the Infection Control Nurse, on 10/21/11 at 10:30 a.m., indicated the nurse was expected to wash her hands between residents.  3.1-18(l)		designee will review this process daily 5 X weekly to ensure that the audits are being completed and that staff are following good handwashing and infection control techniques. Any patterns will be brought to the QA&A committee on a monthly basis.		