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 07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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
F000000	This visit was for the Investigation of Complaints IN00130993, IN00132061, and IN00132247. Complaint IN00130993 - Unsubstantiated due to lack of evidence. Complaint IN00132061 - Substantiated. Federal/state deficiencies related to the allegations are cited at F333. Complaint IN00132247 - Unsubstantiated due to lack of evidence. Survey dates: July 15, 16, & 17, 2013 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Survey team: Diana Zgonc, RN-TC Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 12	F000000	**DISCLAIMER:** **Preparation, submission and implementation of this Plan of Correction does not constitute an admission of our agreement with the facts and conclusions as set forth on the Survey Report. It is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care provided. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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 07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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
	Medicaid: 67 Other: 6 Total: 85 Sample: 4 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed July 21, 2013; by Kimberly Perigo, RN.		**submission of a Plan of Correction within ten (10) days of the Survey Report as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.**	

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 07/17/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203	

(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
F000333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure staff followed physician's orders for pain medications which likely caused respiratory arrest due to CNS (central nerves system) depressants for 1 of 3 residents reviewed for pain medications in a sample of 3 (Resident #B, RN #1, LPN #2, LPN#3, and LPN #4). Findings include: The record for Resident #B was reviewed on 7/15/13 at 10:00 A.M. Diagnoses for Resident #B included, but were not limited to tracheostomy & chronic respiratory failure, quadriplegia, gastrostomy tube, neurogenic bladder, anxiety, obesity, depressive disorder, hypertension, esophageal reflux, unspecified drug dependence abuse, insomnia, and contractures of ankle and foot joint. Resident #B was admitted to the facility on 8/10/12 and discharged on 3/27/13. Recapitulation of the physician's	F000333	**1. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident B has been discharged from the facility 2. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Audit will be performed to ensure all residents receiving pain medications that pain medications are administered as prescribed. Audits to check the physician's order, and that transcription and orders on the MAR are clear and precise will be completed by August 9, 2013. 3. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DNS, ADNS, Unit Managers/Designee will audit any new pain orders 5 days a week during Clinical Start Up. DNS and Medical Director will discuss the results of the new pain order audits and all unclear medication orders. DNS/Designee will notify MD's**	08/16/2013

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 07/17/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203	

(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
	orders for March 2013, indicated the resident was prescribed: -Dilaudid (pain medication) - 2 milligrams (mg/dosage) by mouth PRN (as needed) every 6 hours - Dilaudid - 4 mg by mouth PRN every 6 hours. (FDA Boxed Warning: Drug is a potent Schedule II opioid agonist with highest abuse potential and risk of causing respiratory depression. Alcohol, other opioids, and CNS depressants potentiate respiratory depressant effects, increasing risk of potentially fatal respiratory depression) -Ambien - 5 mg by mouth at bedtime (sedative-hypnotic to treat insomnia. Depresses CNS-central nervous system) -Baclofen - 10 mg by mouth every day at bedtime (muscle relaxant - other CNS depressants can cause increased CNS depression and increased baclofen effect) -Fentanyl - (Duragesic-pain medication) Transdermal Patch (placed on skin) 75 mcg (micrograms) every 72 hours (Duragesic are Schedule II opioid agonist with highest potential for abuse and risk of fatal overdose due to respiratory depression. Fentanyl levels peak between 24 and 72 hours of treatment; serious or life-threatening		**office of any medication order that is unclear to obtain clarification. Licensed nurses will be reeducated by August 16, 2013 on transcription of new pain medication orders and re-educated that medications are to be administered in accordance with written orders of prescriber. All licensed staff will receive education on transcription of new PRN pain medication orders that will include a maximum dose allowed in a 24 hour time frame as well as the process for tracking the dosages given. All newly hired licensed staff will received education on transcription of new pain medication orders and re-educated that medications are to be administered in accordance with written orders of prescriber as well as education on transcription of new PRN pain medication orders that shall include a maximum dose allowed in a 24 hour time frame and the process for tracking the dosages given. The education of licensed nurses both long term licensed staff as well as newly hired licensed staff will include a skills validation to ensure clear understanding of PRN pain medication.All PRN pain medication orders**	

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 07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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
	hyperventilation may arise during initial Duragesic application period) Resident #B's "Controlled Medication Accountability" (receipt/record/disposition) narcotics sheet dated 3/25/13 was reviewed on 7/15/13 at 4:15 P.M., and indicated the following: Hydromorphone (Dilaudid - 2 mg) Take one tablet (2 mg) by mouth every 6 hours as needed for moderate pain; Take two (2) tablets (4 mg) by mouth every 6 hours as needed for severe pain. Doses administered as follows: 3/26/13 at 12 A.M., 1 tablet (2 mg) administered by RN #1 3/26/13 at 3 A.M., 2 tablets (4 mg) administered by RN #1 3/26/13 at 6 A.M., 1 tablet (2 mg) administered by RN #1 3/26/13 at 9 A.M., 2 tablets (4 mg) administered by LPN #2 3/26/13 at 12 Noon, 1 tablet (2 mg) administered by LPN #2 3/26/13 at 4 P.M., 2 tablets (4 mg) administered by LPN #3 3/26/13 at 10 P.M., 2 tablets (4 mg) administered by LPN #3 3/27/13 at 12 A.M., 1 tablet (2 mg) administered by LPN #4 Review of the resident's medication		**will be audited to ensure that they include a maximum dose allowed in a 24 hour time frame. The maximum dose will include any routine pain medication orders of the same medicine. The facility now has an automated dispensing machine that will not dispense further medications. 4. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: New orders for pain medicine will be audited 5 times a week in Clinical Stand Up. Pharmacist will review those residents on routine scheduled narcotics and PRN Narcotics monthly for recommendations.DNS/ADNS/ Designee will report findings of audits to monthly QA meetings for 6 months, and thereafter decreased to an as needed basis as determined by the QA Committee. Any patterns or trends will have an action plan written and interventions implemented. DNS/ADNS/Designee will review PRN pain medications given in a 24 hour period 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then once a week for 4 weeks, then as needed as determined by the QA**	

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 07/17/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203	

(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
	administration record (MAR) for March 2013 indicated the record lacked documentation of all doses of Dilaudid given, but the dose administered at 12 noon. Ambien 5 mg was administered on 3/27/13 at 12 A.M., Baclofen 10 mg administered on 3/26/13 at 2100 (9 P.M.) and a new Fentanyl Patch - 75 mcg placed on the resident on 3/26/13 at 9:00 A.M. A nurses note dated 3/27/13 at 1:40 A.M., indicated the resident rated her pain at 0-1 on the pain scale of (0-10 = 0 being no pain and 10 being the worst pain) and then went back to sleep. A nurses note dated 3/27/13 at 4:26 A.M., indicated the resident was unresponsive to verbal or physical stimuli at 3:50 A.M., was pale in color and could not find a pulse. CPR (cardiopulmonary resuscitation) was initiated and 911 was called. The resident was transported to the hospital by ambulance. EMT's (emergency medical technician) report dated 3/27/13, indicated the resident was negative for brachial and radial pulses but positive for a femoral pulse and heart sounds. Her pupils were dilated at 7		**Committee. 5. Date of Compliance: August 16, 2013.**	

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 07/17/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203	

(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
	mm (millimeters) and the facility staff was assisting resident with ventilations. The resident was transported to the hospital. Review of the hospital notes indicated the resident was seen in the ED (emergency department) on 3/27/13 at 4:20 A.M. Assessment of the resident indicated she was unresponsive with a trach in place. She also had received 2 mg of Dilaudid, 5 mg of Ambien, and had a Fentanyl patch on at the time of admission. The resident received Narcan 0.8 mg (drug used for the management of overdoses) while in the emergency room with no improvement in mental status and admitted to the ICU (intensive care unit). Review of the hospital discharge summary dated 3/29/13 indicated, "anoxic brain injury due to respiratory arrest: appears to be a severe event ... arrest likely due to primary respiratory event likely due to CNS depressants ..." During an interview with the Assistant Director of Nursing (ADON) on 7/16/13 at 9:50 A.M., she indicated there was an order for scheduled Dilaudid, but when she returned from			

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 07/17/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203	

(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
	the hospital on 3/11/13 it was discontinued and not reordered. A current facility policy dated 5/12 and titled "Medication Administration - General Guidelines" and provided by the ADON on 7/16/13 at 4:30 P.M., indicated: "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices ... Procedures: ... 4) Five Rights - ... right dose and right time, are applied for each medication being administered. ... B. Administration: ... 2) Medications are administered in accordance with written orders of the prescriber ..." This Federal tag relates to Complaint IN00132061. 3.1-48(c)(2)			