STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	12/04/2017

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00243799, IN00244304 and IN00246824. Complaint IN00243799 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00244304 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656. Complaint IN00246824 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656. Unrelated deficiencies are cited. Survey dates: November 29, 30 and December 4, 2017 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type:	F 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare: 4 Medicaid: 41 Other: 7 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on December 08, 2017.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and			

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	psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure care plans for smoking (Resident C) and weight loss (Resident D) were initiated for 2 of 10 residents reviewed for care plans in a sample of 11. Findings include: 1. The record for Resident C was reviewed	F 0656	**F656D** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Resident C and Resident D no longer reside at facility **Other residents having the**	12/29/2017

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	on 11/30/17 at 2:10 p.m. Diagnoses for Resident C included but were not limited to, end stage renal disease, peripheral vascular disease, congestive heart failure and atrial fibrillation. The resident was admitted to the facility on 9/4/17 and signed the "Smoking and Tobacco Use Guideline" at that time. The most current Minimum Data Set assessment dated 9/11/17, indicated Resident C had a Brief Interview of Mental Status (BIMS) score of 15/15 (cognitively intact). During an interview with the Social Worker, on 11/30/17 at 2:50 p.m., she indicated Resident C would smoke in areas not designated for smoking and smoke during times when supervision was not available. A progress note, dated 9/4/17 (no time documented), indicated the resident was a smoker and declined a nicotine patch for smoking cessation at that time and was aware of the smoking policy and times. The record lacked documentation of a care plan for smoking and for non-compliance with the smoking policy.		**potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All residents who smoke have been reviewed to ensure a smoking care plan is in place. All residents identified with a weight loss in past 30 days have been reviewed to ensure a weight loss care plan is in place. **The measures put into place and the systemic changes made are as follows:** All licensed nursing staff including SSD in-serviced that care plans are initially put in place when clinical health status form is completed for all new admissions and care plans reviewed/revised with any change of condition or at least quarterly to follow the MDS schedule. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** DNS/designee to audit at clinical start up all new admissions to ensure any resident identified to smoke has a smoking care plan in place. DNS/designee to audit any resident identified to have a significant weight loss at clinical	

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	2. The record for Resident D was reviewed on 11/30/17 at 11 a.m. Diagnoses for Resident D included but were not limited to end stage renal disease (dialysis Monday, Wednesday & Friday), hypertension and cardiovascular accident (stroke). Parameters for severe weight loss are determined by a greater than 5% loss in 1 month. A Registered Dietician note dated 10/20/17 indicated the resident had an 8% weight loss from October (129 pounds) - November (118 pounds) 2017 and recommended increasing the Nepro (renal patient) supplement to twice a day from daily. The record lacked documentation of a care plan for the severe weight loss. During an interview with the Assistant Director of Nursing (ADON-interim Director of Nursing) on 12/4/17 at 10:10 a.m., she indicated care plans for smoking and weight loss could not found. This Federal tag relates to Complaint IN00244304 and IN00246824. 3.1-35(a)		start up to ensure a weight loss care plan is in place. These audits to be completed 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days, then weekly x 90 days. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records			

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	are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure medications for a discharged resident were disposed of according to the facility policy for 1 of 1 resident reviewed for medication disposal in a sample of 11 (Resident N). Findings include: A facility reported incident (FRI) dated 11/8/17, indicated controlled substances were dispensed from an automated dispensing unit (ADU) after the resident had discharged from the facility. The record for Resident N was reviewed on 12/4/17 at 3:00 p.m. Diagnosis for Resident N included but was not limited to cellulitis of the left lower extremity. The resident was admitted on 10/9/17 and discharged on 10/21/17. Resident N had a physician's order for hydrocodone (narcotic) with Tylenol, 7.5-325 milligrams (7.5 mg hydrocodone with 325 mg Tylenol) every 4 hours PRN (as needed) for pain. A pharmacy report provided by the	F 0755	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Resident N no longer resides at facility. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** Residents discharged in the past 14 days reviewed to ensure medications were disposed of per facility guidelines. **The measures put into place and the systemic changes made are as follows:** Narcotic dispense record will be pulled daily and reviewed during the Clinical Start Up to identify discrepancies and/or unusual PRN narcotic use. DNS/designee to audit any discharged resident to ensure any narcotics present have been disposed of properly and to ensure that Alixa has been notified that resident has been discharged. These audits to be completed 5 times per week times 4 weeks, then 3 times per week	12/29/2017

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	Administrator, on 12/4/17 at 4:00 p.m., indicated beginning 10/22/17 (after Resident N's discharge) through 11/8/17, 99 doses of the hydrocodone were dispensed under the Director of Nursing's (DON) name. During an interview with the Administrator on 12/4/17 at 12:20 p.m., he indicated the facility has closed their portion of the investigation into drug diversion. The DON was terminated on 11/30/17 and a letter has been forward to the Professional Licensing Agency. The staff have been inserviced regarding drug disposal and the pharmacy report is now being reviewed by 2 staff members (the Administrator and the DON). During an interview with the Administrator on 12/4/17 at 3:00 p.m., he indicated the pharmacy investigation is still on-going. At this point, the only resident we know for sure that drugs were dispensed after discharge was Resident N. When the pharmacy concludes their investigation those resident's and/or their insurance companies will be reimbursed. During an interview with the Administrator and ADON (interim DON) on 12/4/17 at 4:30 p.m., they indicated 2 nurses are required to dispose of any unused controlled substances.		times 4 weeks, then 2 times per week times 4 weeks, then weekly times 3 months. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	On 12/4/17 at 4:00 p.m., the Assistant Director of Nursing (ADON) provided the Disposal of Medications and Medication-Related Supplies-Controlled Substance Disposal policy, dated 6/15, and indicated the policy was the one currently being used by the facility. "Policy - Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage disposal and recordkeeping [sic] in the facility in accordance with federal and state laws and regulations. Procedures - ... B. When a dose of a controlled medication is removed from the container for administration but ... not given for any reason, it is not place back in the container. It is destroyed in the presence of **(two licensed nurses**), and the disposal is documented on the accountability record/book on the line representing that dose ... C. All controlled substances remaining in the facility after a resident has been discharged, or the order is discontinued, are disposed of: 1. In the facility by the (administrator), director of nursing and/or consultant pharmacist (or others as allowed by state law); ...."			

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