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	08/04/2021

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00358218 and Complaint IN00357258. Complaint IN00358218 - Unsubstantiated due to lack of evidence. Complaint IN00357258 - Unsubstantiated due to lack of evidence. Survey dates: July 28, 29, 30, 31, August 2, 3, and 4, 2021 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 2 Medicaid: 48 Other: 11 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on August 09, 2021.	F 0000	This plan of correction is respectfully submitted as an evidence of alleged compliance of August 23rd, 2021. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that the corrections to the areas cited have been made and the facility is in the compliance with the participation requirements. Golden Living Centers – Indianapolis is respectfully requesting paper compliance.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse,			

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

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	08/04/2021

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
	and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the			

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	08/04/2021

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
	individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure a resident's code status preference was documented accurately in the clinical record for 1 of 25 residents reviewed for advanced directives. (Resident 9) Findings include: On 8/2/21 at 10:51 a.m., the clinical record for Resident 9 was reviewed. The quarterly MDS (Minimum Data Set) assessment, dated 5/4/21, indicated Resident 9 was cognitively intact. Resident 9's face sheet (none dated) indicated the resident was a full code (meaning a desire for all life sustaining measures to be implemented). Physician Orders, dated 8/2/21, indicated Resident 9 was a full code effective 6/6/21, with no stop date noted. Resident 9's care plan, initiated on 3/22/18 and current through 8/2/21, indicated "Patient [Resident 9] has an Advance Directive as evidenced by: Do Not Resuscitate and my wishes will be honored..." On 8/3/21 at 8:50 a.m., the Director of Nursing (DON) provided a copy of Resident 9's POST (Indiana Physician Orders for Scope of Treatment) form, dated 10/23/20. A review of the document indicated, Resident 9's code status was "Do not attempt resuscitation/DNR." Resident 9 signed the form on 10/22/20, and the Physician signed the form on 10/23/20. No other POST form was provided.	F 0578	The facility does ensure the electronic health record and clinical record reflect the advanced directive for a resident in a timely manner. The advance directive was updated in the electronic health record and clinical record for Resident G. All residents have the potential to be affected. An audit of all residents was conducted to ensure the current advance directive is reflected in the electronic health record and the clinical record of each resident. Any negative findings were corrected immediately. Licensed staff were educated that a resident admitting/readmitting to facility should have code status verified and order is input as soon as possible. For a period of 60 days, Director of Nursing or designee will audit new admissions to determine if the advance directive is reflected correctly in the electronic health record and the clinical record for each new resident. Then the Director of Nursing or designee will audit two admissions each week for four weeks. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next six months to identify any trends or patterns. If any issues identified, will continue audits based on IDT	08/23/2021

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	08/04/2021

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
	During an interview, on 8/2/21 at 9:30 a.m., Registered Nurse (RN) 4 indicated Resident 9 was considered a full code as indicated on the face sheet located in the clinical record. During an interview, on 8/3/21 at 9:10 a.m., the DON indicated Resident 9's preferred code status was that of DNR and the clinical record was inconsistent with the Resident's preferred code status. During an interview, on 8/3/21 at 10:35 a.m., Resident 9 indicated "last October" he decided to be a DNR and that decision was discussed with the facility staff at that time. On 8/3/21 at 1:40 p.m., the DON provided a copy of the Resident Rights Regarding Treatment and Advanced Directives, dated 2021, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...it is the policy of this facility to support and facilitate a resident's right to formulate an advance directive...any decision-making regarding resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care..." 3.1-4(f)(4)(A)(ii)		recommendation, otherwise will review on a PRN basis. Please see attached Exhibit A	
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)			

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	08/04/2021

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
	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 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 interview and record review, the	F 0656	- Resident 52 does not	08/23/2021

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	08/04/2021

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
	facility failed to ensure a person-centered care plan was in place for a resident prescribed antidepressants, antianxiety, and a sedative medication for 1 of 24 residents reviewed for care plans. (Resident 52) Findings include: On 8/2/21 at 10:00 A.M., a review of Resident 52's clinical record indicated, diagnoses included, but were not limited to, insomnia, generalized anxiety disorder and major depressive disorder. The Physician's orders for August 2021 indicated, Resident 52 was prescribed buspirone (a prescription medication used to treat anxiety) 10mg (milligrams) via g-tube (A gastrostomy tube is a tube inserted through the abdomen that delivers nutrition directly to the stomach) three times daily for anxiety (start date 6/10/21), clonazepam (a prescription medication used to treat anxiety) 1mg via g-tube three times daily for anxiety (start date 6/10/21), duloxetine delayed release (a prescription medication used to treat depression) 60mg via g-tube daily for depression (start date 6/10/21), mirtazapine (a prescription medication used to treat depression) 7.5mg via g-tube at bedtime for appetite stimulant (start date 6/21/21) and zolpidem (a prescription medication used to treat insomnia) 5mg via g-tube at bedtime related to insomnia (start date 6/22/21). The medication administration record, dated August 2021, indicated, Resident 52 received buspirone 10mg, clonazepam 1mg, duloxetine 60mg, mirtazapine 7.5mg and zolpidem 7.5mg as ordered by the physician.		reside at the facility any longer and was discharged to home. - All other residents in the facility have the potential to be affected. - All residents on an anti-depressant, hypnotic, anxiolytic, or anti-psychotic medications will be audited and care plans will be updated as needed. - All orders will be reviewed in daily morning clinical meeting and care plan will be updated as needed in the clinical meeting. - An audit will be completed of all residents and tracking sheet for all new orders, new residents, type of medications and make sure all care plans are updated accordingly. - Licensed nursing staff will be in-serviced. The DON, Unit Managers, and/or designee will audit the orders 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit B	

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	08/04/2021

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
	The clinical record lacked a person-centered care plan for antidepressant medications, antianxiety medications and sedatives. During an interview, on 8/3/21 at 2:20 P.M., the Regional Nurse indicated, antidepressants, antianxiety and sedatives should have been care planned. The clinical record lacked a person-centered care plan for antidepressant medications, antianxiety medications and sedatives. On 8/3/21 at 10:30 A.M., the Director of Nursing provided a copy of a facility policy, titled "Comprehensive Care Plans," dated 11/2017, and indicated this was the current policy used by the facility. A review of the policy indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan ...that includes measurable objectives and timeframes ..." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.			

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	08/04/2021

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
	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to reassess the effectiveness of the current interventions and failed to revise the resident's care plan to meet the resident's personal care needs for 1 of 19 residents reviewed for comprehensive person centered care plan revisions. (Resident 47) Findings include: On 7/29/21 at 9:45 a.m., observed Resident 47 resting in bed. Resident 47's index fingernail on his left hand was approximately ½ inch in length beyond the nail bed, dark colored, jagged, and was curled around the end of his finger. The right hand's index, middle, and ring fingernails were approximately ½ inch in length beyond the nail bed and each nail was observed to be dark colored and jagged. During an interview, at that time, Resident 47 indicated staff had not trimmed or filed his nails for "a very long time" and he wanted his nails trimmed and filed. On 7/30/21 at 2:18 p.m., observed Resident 47	F 0657	- Resident 47 continues to reside in the facility. - Resident 47 and all other residents in the facility have potential to be affected. - An audit will be completed on all residents' care plans for accuracy and updated as needed. Care plans will be updated daily in the morning meeting with new orders. - An audit will be completed tracking all new orders, d/c orders, Anti-infectives, wound etc. along with personal hygiene care plans or refusal of care will be updated. - Nursing staff to be in-serviced regarding personal hygiene and/or refusal of care documentation. - The DON, unit managers, and/or designee will audit the orders for 5 days a week x 6 weeks, and then weekly x 6	08/23/2021

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	08/04/2021

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
	resting in bed. Resident 47's index fingernail on his left hand was approximately ½ inch in length beyond the nail bed, dark colored, jagged, and was curled around the end of his finger. The right hand's index, middle, and ring fingernails were approximately ½ inch in length beyond the nail bed and each nail was observed to be dark colored and jagged. On 8/2/21 at 9:35 a.m., observed Resident 47 resting in bed. Resident 47's index fingernail on his left hand was approximately ½ inch in length beyond the nail bed, dark colored, jagged, and was curled around the end of his finger. The right hand's index, middle, and ring fingernails were approximately ½ inch in length beyond the nail bed and each nail was observed to be dark colored and jagged. On 7/30/21 at 2:49 p.m., Resident 47's clinical record was reviewed. Diagnosis included, but were not limited to, dementia with behavioral disturbance. The significant change Minimum Data Set (MDS) assessment, dated 7/6/20, dated Resident 47 was severely cognitively impaired and required the assistance of 1 staff for personal hygiene (including washing/drying hands). The following progress notes indicated: On 4/2/21 at 2:43 a.m., "Resident refused p.m. care that was offered at 9:00 p.m. by Certified Nursing Assistant (CNA)." On 4/7/21 at 4:43 a.m., "Resident refused care for the shift of 6p [p.m.] - 6a [a.m.]." On 4/16/21 at 2:57 a.m., "Resident refused care		months. The result of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit C	

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	08/04/2021

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
	from CNA. Resident stated he did not want CNA to use water or soap to clean him up. Resident attempted x3 [3 times]." On 4/18/21 at 7:47 a.m., "Resident refused care x2 [2 times]." On 4/28/21 at 2:42 a.m., "CNA in to assist resident with care ...resident stated he did not want a bed bath or shower." On 6/13/21 at 5:04 a.m., "Resident allowed CNA to change brief only, refused all other P.M. care x3 [3 times]. On 8/2/21 at 10:39 a.m., "Resident declined being shaved and nails being trimmed today." On 8/2/21 at 1:40 p.m., the Director of Nursing (DON) provided a copy of Resident 47's Resident Shower Sheet/Skin Conditions documents, dated from 5/17/21 to 8/2/21. A review of the documents indicated 24 occurrences where Resident 47 refused showers and nail care. On 8/2/21 at 1:40 p.m., the DON provided a copy of Resident 47's care plan. A review of the care plan indicated, "focus: I have a physical functioning deficit related to: self care impairment...date initiated: 7/17/2020; target date: 10/17/21; interventions: personal hygiene and bathing assistance of 1, date initiated 7/17/20; revision date 8/4/20." On 8/2/21 at 2:23 p.m., the DON provided a copy of Resident 47's care plan. A review of the care plan indicated, "focus: I sometimes have behaviors which include Rejection of care, date initiated 11/9/20; goal ...my behavior will stop			

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	08/04/2021

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
	with staff intervention, date initiated: 11/9/20; revision date: 1/8/21; target date: 10/17/21; interventions ...attempt interventions before my behaviors begin, date initiated: 11/9/20; revision date 1/8/21." The current care plan had not been updated to reflect Resident 47's continued refusal for personal hygiene care, including bathing and nail care. During an interview, on 8/2/21 at 9:30 a.m., Qualified Medications Aide (QMA) 8 indicated Resident 47 frequently refused showers and nail care. During an interview, on 8/2/21 at 9:40 a.m., Registered Nurse (RN) 4 indicated Resident 47's shower days were on Thursday's and Saturday's and he usually refused showers and nail care, even after multiple attempts. During an interview, on 8/2/21 at 2:05 p.m., the DON indicated Resident 47's comprehensive care plan should have been revised and updated to include interventions regarding his refusal for personal care, specifically for showers and nail care. On 8/3/21 at 8:50 a.m., the DON provided a copy of the Comprehensive Care Plans policy, dated 2020, and indicated it was the current policy in use by the facility. A review of the policy indicated, "It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's			

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	08/04/2021

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
	comprehensive assessment ...the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being alternative interventions will be documented ...the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record..." 3.1-35(d)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure a resident's arteriovenous fistula was routinely assessed and monitored for 1 of 1 resident reviewed for quality of arteriovenous fistulas care. (Resident 18) Findings include: During a tour of the facility on 8/2/21 at 2:20 P.M., Resident 18 was resting in bed. Observed an arteriovenous fistula (a surgical connection that's made between an artery and a vein for dialysis access) in Resident 18's left upper extremity. On 7/30/21 at 1:00 P.M., a review of Resident	F 0684	- Resident 18 continues to reside in the facility. - Resident 18 and all other residents reside in the facility have potential to be affected. - A thorough audit will be conducted for all residents using fistulas, g-tubes, Foley catheters etc. The orders and care plans will be updated in daily clinical morning meeting and/or as needed. - An audit was complete for all residents, and track sheet for all new orders, new residents with ally of the above and care plan updates.	08/23/2021

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	08/04/2021

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
	18's clinical record indicated, diagnoses included, but were not limited to, diabetes mellitus type 2, chronic kidney disease stage 5, schizophrenia and dementia. An admission skin evaluation, dated 4/30/21 at 2:34 P.M., indicated, Resident 18 had a fistula in the left upper extremity. The admission Minimum Data Set assessment, dated 5/11/21, indicated, Resident 18 was severely cognitively impaired. A Physician's Assistant note, dated 5/4/21, indicated, due to hypertension and diabetes mellitus Resident 18 had a left arm fistula placed in March 2021. Per discussion with daughter, due to mental decline and history of schizophrenia the resident is not a candidate for hemodialysis. The clinical record, dated after 4/30/21 at 2:34 P.M. to current date of 7/30/21, lacked documentation of assessment, monitoring, and care of the fistula. A blood pressure report, dated 8/2/21, indicated, Resident 18's blood pressure was assessed using the left upper extremity on 4/30/21, 5/27/21, 5/28/21, 5/29/21, 5/30/21, 6/10/21, 6/12/21, 6/13/21, 6/25/21, 6/27/21, 7/2/21, 7/8/21, 7/9/21, 7/11/21, 7/15/21, 7/16/21, 7/23/21, 7/24/21 and 7/30/21. During an interview, on 8/2/21 at 11:15 A.M., RN 4 indicated, there were no residents on RN 4's hall with a arteriovenous fistula or on dialysis. Resident 18 was on RN 4's hall. During an interview, on 8/2/21 at 11:30 A.M.,		- Nursing staff to be in-serviced regarding the residents who use fistulas, g-tubes, and catheters. - The DON, unit managers, and/or designee will audit the orders for 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit D	

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	08/04/2021

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
	the Director of Nursing indicated, there were no residents on dialysis or with a fistula in the facility as done with nursing. On 8/4/21 at 10:30 A.M., the regional nurse provided a copy of a facility policy, titled "Hemodialysis," dated 11/2017, and indicated this was the current policy used by the facility. A review of the policy indicated, "The nurse will ensure the dialysis access site is checked ...every shift for patency by auscultating for a bruit and palpating for a thrill ...the resident will not receive blood pressures on the arm where the dialysis access device is located." 3.1-37(a)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to investigate underlying causes of a resident's anxiety and agitation and failed to develop and implement person centered individualized interventions for a resident with behaviors, which led to intimidating episodes to staff and other residents for 1 of 1 resident reviewed for behaviors. (Resident 34)	F 0740	- Resident 34 continues to reside in the facility. - Resident 34 and all other residents in the facility have potential to be affected. - A thorough audit was completed on all residents with behaviors to ensure individualized behavior care plans, also a review	08/23/2021

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	08/04/2021

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
	Findings include: During a resident council meeting, on 8/2/21 at 11:10 a.m., resident council members indicated some of the residents that resided in the facility were intimidated by Resident 34. Resident 34 liked a certain chair when he went outside to smoke. If another resident was sitting in his favorite chair when he went out, he would yell at whoever was sitting in the chair and intimidate the resident into moving. On 8/3/21 at 10:00 a.m., the Social Services Director (SSD) provided a copy of a grievance form, dated 7/30/21. The form indicated a Statement of Concern/Grievance: "I [Housekeeper 7] was doing my normal clean up like every day. He [Resident 34] wanted his coffee heated up so I helped heat the coffee then put it in his [Resident 34's] room. Before leaving (his room) he raised his hand like he was going to do something and cussed [sic] me out and told me to do my d... job." On 8/3/21 at 10:00 a.m., the Social Services Director (SSD) provided a copy of a grievance form, dated 7/31/21, the form indicated Statement of concern/Grievance: "Name [CNA 6] called me and said that she [CNA 6 was in [Resident 34's] room doing care when [Resident 34] started yelling at her [CNA 6]. She [CNA 6] attempted to ask him [Resident 34] what was wrong and he [Resident 34] got even louder. She [CNA 6] left the room and he [Resident 34] came out in the hall yelling. A nurse went down to his room and got him [Resident 34] quieted down." On 8/3/21 at 10:20 a.m., Resident 34's clinical record was reviewed. Diagnosis included, but were not limited to, paranoid schizophrenia and		of residents' new behaviors in daily morning meeting and will update the care plan at that time. - An audit of all existing resident care plans, tracking sheet for all new residents, new behaviors, new orders, physician notifications, and possible root cause analysis. - Staff to be in-serviced on residents behaviors, and how to manage residents behavior while providing care and services. - The DON, unit managers, and/or designee will audit the orders for 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits to be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit E	

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	08/04/2021

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
	major depressive disorder. A quarterly Minimum Data Set Assessment, dated 6/24/21, indicated Resident 34 was cognitively intact. Behavior symptoms exhibited was "verbal behavior directed toward others" on 1 to 3 days during the 7 day look back period. Care plan initiated on March 13, 2020 with goal current through August 10, 2021 indicated, "Focus: I sometimes have behaviors which include verbal behaviors to others and yelling out. Goal: My behavior will stop with staff intervention." Interventions included, but were not limited to, "Attempt interventions before my behavior begins." Care plan imitated on March 19, 2020 with goal current through August 10, 2021, indicated, "Focus: I sometimes display inappropriate behaviors during group activities. Goal: I will demonstrate appropriate behaviors during group activities." Interventions included, but were not limited to, "If i disrupt the program, calmly redirect me, reminding me that if the behavior continues I may be asked to the the facility." Social Services Progress Note, dated 3/30/21 at 10:19 a.m., indicated "Resident [Resident 34] verbally threatening to residents and staff due to smoking break being late. ...Resident [Resident 34] was not easily redirected." The Social Services Progress notes lacked interventions in response to the behaviors. A document, titled Behavior Symptoms, undated, indicated Resident 34 had experienced threatening behaviors on 7/22/21 at 3:42 a.m., 7/30/21 at 1:59 p.m. and 10:52 p.m., and 8/3/2021 at 9:53 a.m. and 4:28 p.m.. The			

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	08/04/2021

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
	clinical record lacked specific detailed description of the threatening behavior occurring at those times. A Progress note, dated 4/29/21 at 11:39 a.m., indicated "Resident [34] continuing to have cursing and yelling out at staff, on smoke break when staff told him his 5 minutes was up and he had to extinguish his cigarette, resident continued smoking and began cursing out staff..." A Progress note, dated 4/10/21 at 10:30 a.m., indicated "Resident [Resident 34] come at [sic] nursing station with only brief on, start [sic] yelling at all staff members because he asked his CNA to made [sic] his bed after she get [sic] him up. She told him to wait a minute, she will make bed in [sic] few minutes." A Progress note, dated 5/16/21 at 1:59 p.m., indicated "Resident [Resident 34] having aggressive behaviors toward staff and other residents. ...Resident [Resident 34] walking down the hall yelling and cussing [sic] at residents and then at the staff for refusing to let him use the telephone. ..." A Social Services Progress Note, dated 6/25/21 at 10:17 a.m., indicated "...Resident [Resident 34] continues to be verbally belligerent to staff...." A Progress note, dated 7/30/21, indicated. "Resident cursing this a.m., and demanding coffee and refusing to eat breakfast..." A Progress note, dated 8/3/21 at 10:12 a.m., indicated "Resident [Resident 34] has had more behaviors than usual...."			

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	08/04/2021

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
	A Psychiatry Progress note, dated 3/17/2021, indicated "Presenting symptoms included, but were not limited to, irritability, suspicious/paranoid, verbal aggression to staff and yelling out. Review of Systems: included, but were not limited to: Psychological: (+) agitation, and (+) aggression. Assessment and plan: ...Staff to monitor for and report of disturbances, new or worsening behaviors or new/re-emerging distressful hallucinations, delusions or paranoia. Additional text: ...Staff to monitor resident for changes in mood, behavior ...document, and report changes to [name of psychiatry office]." A Psychiatry Progress note, dated 7/27/21, indicated "Treatment Plan: Delusions: Improve frequency, intensity, and severity of Delusional ideation and Affective Distress as measured by self/staff-report, observation, and improved assessment scores, via treatment adherence and using 2-3 interventions/adaptive coping skills as indicated by problem solving, affect regulation, reorientation, redirection/distraction, reality testing, and de-escalation." The clinical record lacked documentation to indicated Psychiatry recommendations, dated March 17, 2021 and July 27, 2021, were added to Resident 34's plan of care. The Physicians orders, dated July, 2021, with a start date of 2/2/21, indicated Resident 34 was prescribed haloperidol decanoate solution inject 300 mg intramuscularly one time a day every 28 days, related to paranoid schizophrenia. Medication Administration Records, dated March 2021 through August 2021, indicated Resident 34 received haloperidol on March 04,			

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	08/04/2021

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
	2021. No dose administered in April, May, June, July, or August 2021. During an interview, on 8/3/21 at 11:33 a.m., the Director of Nursing indicated Resident 34 only had one dose of haloperidol solution in March 2021, he had decided he did not want the medication and refused to take it. The DON was unable to provide documentation Resident 34 was reapproached or educated on his refusal of the Physicians order to administer haloperidol deconate solution. The clinical record lacked documentation of Physician notification of refusal of haloperidol deconate solution. The clinical record lacked a root cause of the behavior. The clinical record lacked assessments, detailed observations, adaptive coping skills, and person centered interventions, related to the root cause of Resident 34's aggressive behaviors. During an interview, on 8/2/21 at 11:50 a.m., Certified Nursing Assistant (CNA) 6 indicated when she provided care to Resident 34 on 8/1/21, at that time he became agitated and held his hand up as though he was going to hit her. CNA 6 also indicated Resident 34 stated "give me your gun so I can blow up the other residents and the staff." CNA 6 indicated she then left Resident 34's room and reported the incident to the charge nurse. CNA 6 indicated other residents are afraid of Resident 34, "he is intimidating." During an interview, on 8/3/21 at 8:45 a.m., Housekeeper 7 indicated during her scheduled			

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	08/04/2021

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
	room cleaning for Resident 34, she entered the resident's room, he then requested a cup of coffee. Resident 34 then began yelling and raised his hand as though he was going to hit Housekeeper 7. Housekeeper 7 then left the room and reported the incident to her supervisor. Housekeeper 7 indicated, "some of the residents are afraid of him." On 8/3/21 at 8:51 a.m., the Director of Nursing provided a policy titled, Behavioral Health Services, dated 2021, and indicted it was the current policy being used by the facility. A review of the policy indicated "It is the policy of this facility that all resident's receive necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. Policy explanation and guidelines:...2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes:...2. d. Ongoing monitoring of mood and behavior; and...f. evaluation. 3. a. be person centered." 3.1-34(a)(1)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident received psychotropic medications as ordered by the Physician for 1 of 1 resident reviewed for significant medication errors. (Resident 61) Findings include:	F 0760	- Resident 61 continue to reside in the facility - Resident 61 and all other residents in the facility have potential to be affected. - A thorough audit on all resident's EMRs to see any	08/23/2021

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	08/04/2021

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
	a.) The clinical record for Resident 61 was reviewed on 7/28/21 at 1:40 P.M. Diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder, schizophrenia disorder, anxiety disorder and vascular dementia with behavioral disturbances. The physician's orders, dated July 2021, indicated, Resident 61 was prescribed haloperidol deconoate (a prescription medication used to treat schizophrenia) 150mg (milligrams) intramuscularly (into the muscle) injection once every 14 days (start date 6/17/21). A Medication Administration Record, dated June 2021 indicated, Resident 61 received haloperidol deconoate 150mg injection on 6/14/21 and again on 6/18/21. During an interview, on 8/3/21 at 9:40 A.M., the Director of Nursing indicated, Resident 61 should not have received the haloperidol injection on 6/18/21. After Resident 61 received the haloperidol injection on 6/14/21. The haloperidol injection order was changed on 6/17/21 from administering the haloperidol injection at 9:00 A.M. to administering the haloperidol injection at 5:00 A.M. When the order was changed, the medication administration record should have been updated to indicate the next dose was due on 6/28/21. On 7/28/21 at 11:00 A.M., the Director of Nursing provided a copy of a facility policy, titled "Medication Administration," dated 11/2017, and indicated this was the current policy used by the facility. A review of the policy		medication errors. - Daily audit of all new medication orders for accuracy of order entry along with discontinuance of previous order. The care plans will be updated at the same time. - Nursing service to be in-serviced on how to prevent any medication errors. - Licensed nursing staff will be in-serviced. The DON, unit managers, and/or designee will audit the orders for 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit F	

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	08/04/2021

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
	indicated, "administer medication as ordered in accordance with manufacturer specifications. Sign medication administration record after administered." b.) The clinical record for Resident 61 was reviewed on 7/28/21 at 1:40 P.M., Diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder, schizophrenia disorder, anxiety disorder and vascular dementia with behavioral disturbances. A Physician's verbal order form, dated 7/28/21 at 10:55 A.M., indicated, Resident 61 was prescribed Ativan (a prescription medication used to treat anxiety) 2mg per milliliter intramuscularly once now. A Medication Administration Record, dated July 2021 indicated, Resident 61 received lorazepam (generic for Ativan) 2mg intramuscularly on 7/28/21. There was no documentation the lorazepam was retrieved from the emergency drug supply and administered. A progress note, dated 7/28/21 at 7:15 P.M., indicated, Resident 61 was transported to Assurance Hospital via stretcher. During an interview, on 7/30/21 at 10:30 A.M., the Pharmacist indicated, to administer the lorazepam injection as ordered, the nurse should have removed the lorazepam from the emergency drug supply. A Pharmacist would have needed to approve the removal due to lorazepam being a controlled substance. The approval was not obtained. The lorazepam was not removed from the emergency drug supply, so the pharmacy sent the lorazepam to the facility. The lorazepam			

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	08/04/2021

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
	arrived at the facility on 7/29/21 at 2:30 A.M. (7 hours after Resident 61 was transported to the hospital) During an interview, on 8/4/21 at 1:45 P.M., the Director of Nursing indicated, there was no documentation that indicated a nurse removed the lorazepam from the emergency drug supply. If the medication was not removed from the emergency drug supply, the nurse should not have documented the lorazepam was administered. On 8/2/21 at 1:17 P.M., the Director of Nursing provided a copy of a facility policy, titled "Automated Dispensing Machine for First Dose and Emergency Medications," dated 8/2014, and indicated this was the current policy used by the facility. A review of the policy indicated, " ...observe the removal of controlled substance from the dispensing unit after it has been approved by the pharmacist." On 7/28/21 at 11:00 A.M., the Director of Nursing provided a copy of a facility policy, titled "Medication Administration," dated 11/2017, and indicated this was the current policy used by the facility. A review of the policy indicated, "administer medication as ordered in accordance with manufacturer specifications. Sign medication administration record after administered." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently			

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	08/04/2021

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
	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. Based on observation, interview, and record review, the facility failed to ensure narcotics were secure behind a double lock in the refrigerator for 1 of 1 refrigerated narcotics and failed to label and date as indicated by facility policy, for 2 of 8 medication carts in the facility. Findings include: 1. During observation of medication storage, on 8/2/21 at 8:50 a.m., observed a bottle of the medication lorazepam (anti-anxiety medication) located in a bin just inside of an unlocked refrigerator in Medication Room B. That bin contained four full bottles of oral liquid lorazepam and two vials of injectable lorazepam.	F 0761	- All residents who reside in the facility have the potential to be affected. - The refrigerator in medication room B was unable to secure the padlock attaching the doorframe was fixed immediately by the maintenance director. - The DON, Unit managers and/or designee will check locks on refrigerators in medications rooms daily including the label and dates in medication carts. - Nursing staff will be in-serviced about the medication room and/or refrigerator door	08/23/2021

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	08/04/2021

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
	During an observation, at that time, RN 3 (Registered nurse) attempted multiple times to lock the refrigerator but was unable to secure the padlock attaching the door to the frame. After multiple attempts, RN 3 contacted maintenance. During an interview, on 8/2/21 at 9:00 a.m., RN 3 indicated refrigerated controlled substances should be secured behind a two-lock system. RN 3 indicated she had "never" seen the refrigerator door locked before. The padlock was hanging unlocked on the refrigerator door. During an interview, on 8/2/21 at 915 a.m., The DON indicated controlled medications should be secured behind a two-lock system. On 8/2/21 at 9:15 a.m., the DON provided a copy of the Medication Storage Policy, titled: Controlled Substance Storage, and indicated it was the current policy in use by the facility. A review of the policy indicated, "Schedule (II-V) medications and other medications subject to abuse or diversion are stored in a permanently affixed (double-locked) compartment separate from all other medications ..." The policy also indicated, "controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator." 2. During a medication administration observation on 7/30/21 at 8:50 A.M., observed inside the narcotic lock box on a medication cart on the B wing a thirty milliliter opened, white, plastic bottle containing an unknown clear liquid substance that lacked a label to indicate what was in the bottle and to whom the bottle belonged. During an interview, on 7/30/21 at 8:51 A.M.,		lock. - The DON, unit managers, and/or designee will audit the orders for 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit G	

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	08/04/2021

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
	LPN 2 Indicated the white plastic bottle contains lorazepam. The bottle should have been labeled to indicate who the bottle belongs to and what was in the bottle. On 8/4/21 at 2:30 P.M., the facility was unable to provide a policy regarding proper labeling of medications prior to exit. 3.1-25(j) 3.1-25(n)			
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the facility's dumpster container lids were kept closed when not in use. Findings Include: During an observation, with the Dietician and Dietary Manager, on 7/28/21 from 12:02 p.m. to 12:08 p.m., observed three separate dumpsters, located adjacent to the kitchen's rear exit door. One dumpster container, located at the farthest from the kitchen door, had 2 top loaded lids which were observed to not be closed. The side panel door, of the same dumpster container, was observed to not be closed. Inside the dumpster were multiple trash bags that contained garbage and unbagged card-board boxes. Multiple large black flies were observed flying around the bagged garbage. No staff were observed near the dumpster area. During an observation with the Dietician, on	F 0814	- All residents reside in the facility have the potential to be affected. - The dumpster container located at the farthest from the kitchen door, had 2 top loaded lids which were fixed and closed properly. The other dumpster door was also closed properly. - Maintenance director and or designee will check the dumpster lids on a daily basis. - Staff will be in-serviced on the use of dumpster and lids to be closed after each use. - The DON, maintenance director, unit managers, and/or designee will check the dumpster lids for 5 days a week x 6 weeks, and then weekly x 6 months. The results of audits will be reviewed in QAPI monthly x 6 months to review for any continued deficient practice. If any deficient practice	08/23/2021

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	08/04/2021

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
	7/29/21 from 1:40 p.m. to 1:44 p.m., observed three separate dumpsters, located adjacent to the kitchen's rear exit door. One dumpster container, located in the middle of the dumpster area, had 1 lid that was observed to not be closed. The dumpster container had visible trash bags that contained garbage hanging over and outside of the dumpster container. Multiple black flies were observed flying around the bagged garbage. No staff were observed near the dumpster area. During an interview, on 7/28/21 at 12:15 p.m., the DM (Dietary Manager) and Dietician indicated the dumpster lids and doors were to be kept closed. On 7/29/21 at 2:21 p.m., the DM provided a copy of the Disposal of Garbage and Refuse policy, dated May 3, 2021, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers...surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized..." On 7/29/21 at 3:30 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(5)		identified the facility will continue audits based on IDT recommendations. - Compliance date – August 23rd, 2021 - Please see attached Exhibit H	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

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	08/04/2021

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
	The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,			

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	08/04/2021

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
	depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure a glucometer (used to obtain a sample of blood to determine blood sugar level) was properly disinfected between residents for 5 of 18 residents who receive accu-checks using the multiple resident use glucometer. (Resident 223, 41, 15, 66 and 59) Findings include:	F 0880	- Residents 223, 41, 15, 66, and 59 continue to reside in the facility. - All residents reside in the facility have the potential to be affected. A RCA has been completed with input from the IP/DON and MD - Nursing staff have been -inserviced about the proper	08/26/2021

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	08/04/2021

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
	On 8/1/2021 at 11:30 a.m., observed Qualified Medication Assistant (QMA) 1 perform an accu-check on Resident 223. No blood was observed on the glucometer at that time. The QMA was observed to not use a Sani-wipe. During and interview, at that time, the QMA indicated she used alcohol preps to clean the glucometer between each resident. The QMA also indicated the same glucometer was used for all the residents who receive accu-check's on hall A. Residents 223, 41, 15, 66 and 59. On 8/3/2021 at 10:22 a.m., the Director of Nursing provided a document that listed all the Residents who receive accu-checks on hall A. The list indicated Resident 223, 41, 15, 66, and 59. On 8/3/2021 at 10:30 a.m., The clinical record of Resident 223's was reviewed. Diagnosis included, but were not limited to, Type 2 diabetes mellitus. Physicians orders, dated July, 2021, with a start date of 7/28/21, indicated accu-check as needed. On 8/3/2021 at 10:45 a.m., the clinical record of Resident 41 was reviewed. Diagnosis included, but were not limited to, Type 2 diabetes mellitus (DM). Physicians orders, dated July 2021, with a start date of 5/4/2021, indicated accu-check daily. A Medication Administration Record, dated July, 2021, indicated Resident 41 received an accu-check every day in July 2021. On 8/3/2021 at 11:00 a.m., the clinical record of Resident 15 was reviewed. Diagnosis included, but were not limited to, type 2 diabetes mellitus (DM). Physicians orders, with a start date 6/20/21, indicated accu-check as needed for diabetes mellitus. A Medication Administration		glucometer cleaning after each use according to manufacturer guidelines and facility policy with competency demonstration and return demonstration. - - 1. The IP nurse/DON/Designee will monitor for glucometer disinfection and systemic change identified in RCA, daily or more often as necessary for 6 weeks and until compliance is maintained. 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified This will occur for 6 weeks and until compliance is maintained. The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. -	

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	08/04/2021

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
	Record, dated July 2021, indicated Resident 15 received an accu-check every day in July 2021. On 8/3/2021 at 11:15 a.m., the clinical record of Resident 66 was reviewed. Diagnosis included, but were not limited to, type 2 diabetes mellitus. Physicians orders, dated July 2021, with a start date of 1/24/21, indicated accu-check on Monday, Wednesday, and Friday. A Medication Administration Record, dated July 2021, indicated Resident 66 received an accu-check every Monday, Wednesday and Friday in July 2021. On 8/3/2021 at 11:30 a.m., the clinical record of Resident 59 was reviewed. Diagnosis included but were not limited to, diabetes mellitus. Physicians orders, dated July 2021, with a start date of 2/12/21, indicated accu-check as needed. A Medication Administration Record, dated July 2021, indicated Resident 59 received accu-checks on 29 of 31 days in July. On 7/30/21 at 8:30 a.m., the Director of Nursing, provided the manufacturing instructions provided inside the accu-check machine packaging, undated, titled Cleaning and Disinfecting Procedures. A review of the document indicated "...2. Open the cap of the disinfectant container and pull out 1 towelette and close the cap. ...3. Wipe the entire surface of the meter 3 times vertically using one towelette to clean blood and other body fluids...." On 7/30/21 at 8:33 a.m., the Director of Nursing, provided a document titled Blood Glucose Monitor Decontamination Skills competency, undated. A review of the document indicated "...After blood glucose testing is compete, while wearing gloves, the nurse uses			

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	08/04/2021

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
	the appropriate cleaning solution/wipe to clean all external parts of the glucometer." 3.1-18(b)			