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	05/09/2017

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 was in conjunction with the Investigation of Complaint IN00228591. Complaint IN00228591 - Substantiated. No deficiencies related to the allegations are cited. Survey Dates: May 1, 2, 3, 4, 5, and 9, 2017 Facility Number: 000063 Provider Number: 155138 AIM number: 100266210 Census bed type: SNF/NF: 58 Total: 58 Census payor type: Medicare: 7 Medicaid: 50 Other: 1 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	05/09/2017

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
	Quality Review completed on May 12, 2017.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under			

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	05/09/2017

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
	paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			
	Based on interview and record review, the facility failed to notify the Physician when a resident had a change in skin condition for 1 of 3 residents reviewed for pressure ulcers. (Resident 9) Findings include: On 05/03/2017 1:08 p.m., Resident #9's clinical record was reviewed Diagnosis included but were not limited to sacral spina bifida. Care plan, dated 01/26/2017, indicated Focus: Pressure ulcer: Resident 9 is at risk due to assistance required in bed	F 0157	**The corrective actions accomplished for those residents to found to have been affected by a deficient practice are as follows:** All resident received a skin assessment and list of room numbers with what day the Skin UDA is due was developed and placed on both units. MD/Res representative notified if any changes were noted. All residents in facility have a new Braden scale assessment done and placed in resident chart. All wound UDA's are current and up to date. All residents with	06/08/2017

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	05/09/2017

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
	mobility and bowel incontinence. Goal: Skin will remain intact. Interventions included but were not limited to: complete Braden scale per Living Center Policy. Provide pressure reduction/relieving mattress. Referral to therapy. Turning and repositioning every two hours. Braden Scale for Predicting Pressure Sore Risk dated 3/31/2017, indicated Resident 9's total score was 17 (at risk for pressure ulcers). Care Plan, dated 04/26/16, indicated Focus: I (Resident 9) have a physical functioning deficit related to: Self care impairment. Goal: included but not limited to inspect skin with care. Report reddened areas, rashes, bruising or open areas to the charge nurse. Medication Administration Record (MAR) dated 04/1/2017 - 4/30/2017, indicated no skin issues. Treatment Administration Record (TAR) dated 04/01/2017 - 4/30/2017, indicated no skin issues. Resident Shower Sheet / Skin Concern Documentation dated 4/25/2017, 4/22/2017, 4/15/2017, 4/4/2017, and 4/1/2017, indicated Resident 9 had		wounds Care Plans were corrected and updated. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows;** All nursing staff In-serviced on Weekly Skin Assessment UDA's and Weekly Wound Assessment UDA's timely completion. MD/Res representative notified if any changes were noted. All nursing staff in-serviced on Braden scale and completing them upon admission and re-admission. **These corrective actions will be monitored and implemented so that the deficient practice does not occur again per the following:** DNS/Designee will review all skin assessments daily for completion. DNS/Designee will review all wound UDA's daily for completion. DNS/Designee will review all new admission Braden scales to ensure completion. Any concerns identified will be corrected by DNS/Designee at time of discovery and	

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	05/09/2017

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
	redness on her buttocks. Resident Shower Sheet / Skin Concern Documentation dated 4/18/2017, indicated redness and an open area on her buttocks. The Clinical Record lacked documentation to indicate the facility reported/acted upon the skin condition reports which indicated skin injury (redness/open area). The Clinical Record lacked documentation of Physician notification. On 5/9/2017 at 9:15 a.m., the DON provided a copy of Pressure Ulcer Risk Identification/Prevention Diagram (undated). The diagram indicated: "... change of condition, complete clinical Health Status 1. Skin assessment to be 1st section completed. 2. Compare assessment findings to risk factors on IPOC [Initial Plan of Care]. Skin risk factors present? Yes: Is pressure ulcer present? Yes: Pressure ulcer identified from admission skin assessment/weekly skin assessment/observation. ... Treatment as ordered ... Plan of care/communication: initiate IPOC and place individual resident interventions and mark problem/risk factors. Notify family and document notification.		MD/Family's to be notified as well. **Tracking record/audit form will be maintained in DNS office.** Audit x5 days weekly for x 60 days, audit x4days weekly x60 days, audit x3 days weekly for 60 days, audit x2 days weekly for 60 days, audit x1 weekly x60 days. **DNS/Designee will report any findings in audits at monthly QAPI meeting for 6 months, any patterns or trends identified will have an action plan written and interventions implemented.**	

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	05/09/2017

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
	Notify: Dietary, Activities and Social Services." On 5/4/2017 at 3:44 p.m., the DON provided a policy dated 1/26/2017, titled: Weekly Skin Review User Defined Assessments (UDA), and also indicated it was the current policy being used by the facility. "Policy Statement: A Weekly Skin Review UDA will be completed weekly on all residents and patients to check for any new skin issues not previously identified. ... This Policy Applies To: Licensed Nursing Staff. ...3. Complete the assessment on the date that it is due. Steps for Completion: ...The "Skin Intact" box is checked only when there are no skin alterations identified. ...If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. ...Medical Director (MD)/Nurse Practitioner (NP) are to be notified of any skin alteration, as well as the resident/patient, and his/her responsible party. ...Care Plans are to be updated with new interventions, and Certified Nursing Assistant (CNA) care sheets updated as indicated." 3.1-5(a)(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	05/09/2017

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 0223 SS=D Bldg. 00	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on record review and interview, the facility failed to ensure a resident was free from verbal and physical abuse for 1 of 2 residents reviewed who met the criteria for investigation of abuse. (Resident 79) Findings include: The clinical record of Resident 79 was reviewed on 5/5/17 at 10:52 a.m. Diagnoses for the resident included, but were not limited to, paralysis on left side,	F 0223	The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Incident was reported to ISDH during annual survey. Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows; All residents interviewed and no reports of abuse identified.	06/08/2017

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	05/09/2017

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
	mood, behavior, anxiety, personality disorders, and depressive episodes. A quarterly Minimum Data Set assessment, dated 3/13/17, indicated Resident 79 was severely impaired in his ability to make decisions. A care plan, dated 2/27/17 and current through 5/27/17, indicated Resident 79 had a potential for abuse due to decreased cognitive and physical disabilities. In a confidential interview, during the survey May 01 - 09, 2017, it was reported having observed a staff member go over to Resident 79, who was banging his cup on the table in the dining room. The staff member pointed a finger at the resident and told him to stop, but the resident banged the cup louder and the staff member reached over and smacked the resident on the arm or hand. A Grievance Form dated 4/12/17, (incident occurred on 4/11/17) indicated "[Resident 89] tearful when he told [weekend/night] nurse about episode in dining room last eve[ning]. States tall skinny black female from dietary smacked [Resident 79's] hand in dining room at supper. Stated he was banging his cup on table like he always does and she took the cup away from him When		The measures put into place and the systemic changes made are as follows: All staff educated on abuse and reporting. The in service will include and stress appropriate responses for staff to resident behaviors. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following: DNS/ED will review all grievances submitted by resident and staff to ensure that reportable concerns are reported immediately. DNS/ED/Designee will monitor staff and resident interaction during meal times and personal care times. Monitoring will occur on Day and Noc shift x7 days weekly x4 weeks, then x6 days weekly x3 weeks, then x5 days weekly x2 weeks, then x4 days weekly x1 week and then x1 day weekly for 6 months. Any findings will be reviewed monthly in QAPI and a plan will be put in place for any findings. Tracking record/audit form will be maintained in DNS office to ensure any allegations of abuse are reported to state in a timely manner.	

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	05/09/2017

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
	he reached for it, she smacked his hand and told him to stop. [Resident 89] said he tried to intervene on [Resident 79's] behalf. She then told [Resident 89) she would do it again and he couldn't do anything about it." An incident investigation, dated 5/5/17, indicated Resident 89 reported Cook 2 slapped Resident 79 on 4/12/17. Dietary aide suspended, MD and families notified. Follow-up allegation of abuse substantiated, dietary aide terminated and in-servicing provided to facility staff. Review of a 3 Step Employee Memorandum initiated 4/12/17, indicated Cook 2 was suspended on 4/12/17 for a Category 1 Violation, "offenses are considered gross misconduct and are subject to immediate suspension, pending investigation for termination if the violation is substantiated." The Memorandum indicated, on 4/14/17, Cook 2 was terminated for a Category 1 Violation [abuse]. On 5/5/17 at 8:44 a.m. the Executive Director provided an undated policy titled, "Preventing Resident Abuse," and indicated it was the policy currently used by the facility. The policy indicated, "Abuse is the willful infraction of injury, unreasonable confinement, intimidation		DNS/ED will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.	

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	05/09/2017

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
	or punishment that results in physical harm, pain or mental anguish...Verbal abuse is any oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment..." 3.1-27(a) 3.1-27(b)			
F 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect			

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	05/09/2017

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
	against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to			

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	05/09/2017

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 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an allegation of abuse was immediately reported to the State Survey and Certifications Agency for 1 of 2 residents who met the criteria for review of abuse. (Resident 79) Findings include: The clinical record of Resident 79 was reviewed on 5/5/17 at 10:52 a.m. Diagnoses for the resident included, but were not limited to, paralysis on left side, mood, behavior, anxiety, personality disorders, and depressive episodes. A quarterly Minimum Data Set assessment, dated 3/13/17, indicated Resident 79 was severely impaired in his ability to make decisions. A care plan, dated 2/27/17 and current through 5/27/17, indicated Resident 79 had a potential for abuse due to decreased cognitive and physical disabilities. In a confidential interview, during the	F 0225	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Incident was reported to ISDH during annual survey. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All residents interviewed and no reports of abuse identified. **The measures put into place and the systemic changes made are as follows:** All staff educated on abuse and reporting. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** DNS/ED will review all grievances submitted by resident and staff to	06/08/2017

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	05/09/2017

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
	survey May 01 - 01, 2017, it was reported having observed a staff member go over to Resident 79, who was banging his cup on the table in the dining room. The staff member pointed a finger at the resident and told him to stop, but the resident banged the cup louder and the staff member reached over and smacked the resident on the arm or hand. A Grievance Form, dated 4/12/17 (incident occurred on 4/11/17), indicated "[Resident 89] tearful when he told [weekend/night] nurse about episode in dining room last eve[ning]. States tall skinny black female from dietary smacked [Resident 79's] hand in dining room at supper. Stated he was banging his cup on table like he always does and she took the cup away from him When he reached for it, she smacked his hand and told him to stop. [Resident 89] said he tried to intervene on [Resident 79's] behalf. She then told [Resident 89) she would do it again and he couldn't do anything about it." An incident investigation, dated 5/5/17, indicated Resident 89 reported Cook 2 slapped Resident 79 on 4/12/17. Dietary aide suspended, MD and families notified. Follow-up allegation of abuse substantiated, dietary aide terminated and in-servicing provided to facility staff.		ensure that reportable concerns are reported immediately. **Tracking record/audit form will be maintained in DNS office to ensure any allegations of abuse are reported to state in a timely manner.** **DNS/ED will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.**	

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	05/09/2017

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 5/9/17 at 10:10 a.m., the Director of Nursing indicated she was unable to find documentation that this alleged incident of abuse was reported to the Indiana State Department of Health prior to 5/5/17. On 5/5/17 at 8:44 a.m., the Executive Director provided an undated policy titled, "Preventing Resident Abuse," and indicated it was the policy currently used by the facility. The policy indicated, "Any associate who suspects that a resident has been abused must immediately notify the executive director, who will notify the regional vice president and appropriate state agencies in accordance with the law..." 3.1-28(c)			
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and			

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	05/09/2017

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
	misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.			
	Based on record review and interview, the facility failed to develop and implement written policy and procedures to ensure an allegation of abuse was immediately reported to the State Survey and Certification Agency for 1 of 2 residents who met the criteria for review of abuse. (Resident 79) Findings include: The clinical record of Resident 79 was reviewed on 5/5/17 at 10:52 a.m. Diagnoses for the resident included, but	F 0226	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Incident was reported to ISDH during annual survey. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All residents interviewed and no reports of abuse identified.	06/08/2017

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	05/09/2017

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
	were not limited to, paralysis on left side, mood, behavior, anxiety, personality disorders, and depressive episodes. A quarterly Minimum Data Set assessment, dated 3/13/17, indicated Resident 79 was severely impaired in his ability to make decisions. A care plan, dated 2/27/17 and current through 5/27/17, indicated Resident 79 had a potential for abuse due to decreased cognitive and physical disabilities. In a confidential interview, during the survey May 01 - 09, 2017, it was reported having observed a staff member go over to Resident 79, who was banging his cup on the table in the dining room. The staff member pointed a finger at the resident and told him to stop, but the resident banged the cup louder and the staff member reached over and smacked the resident on the arm or hand. A Grievance Form dated 4/12/17 (incident occurred on 4/11/17), indicated "[Resident 89] tearful when he told [weekend/night] nurse about episode in dining room last eve[ning]. States tall skinny black female from dietary smacked [Resident 79's] hand in dining room at supper. Stated he was banging his cup on table like he always does and		**The measures put into place and the systemic changes made are as follows:** All staff educated on abuse and reporting. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** DNS/ED will review and submit all reportables according to ISDH guidelines. **Tracking record/audit form will be maintained in DNS office to ensure any allegations of abuse are reported to state in a timely manner.** **DNS/ED will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.**	

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	05/09/2017

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
	she took the cup away from him When he reached for it, she smacked his hand and told him to stop. [Resident 89] said he tried to intervene on [Resident 79's] behalf. She then told [Resident 89) she would do it again and he couldn't do anything about it." An incident investigation, dated 5/5/17, indicated Resident 89 reported Cook 2 slapped Resident 79 on 4/12/17. Dietary aide suspended, MD and families notified. Follow-up allegation of abuse substantiated, dietary aide terminated and in-servicing provided to facility staff. On 5/9/17 at 10:10 a.m. the Director of Nursing indicated she was unable to find documentation that this alleged incident of abuse was reported to the Indiana State Department of Health. On 5/5/17 at 8:44 a.m. the Executive Director provided an undated policy titled, "Preventing Resident Abuse," and indicated it was the policy currently used by the facility. The policy indicated, "Abuse is the willful infraction of injury, unreasonable confinement, intimidation or punishment that results in physical harm, pain or mental anguish...Verbal abuse is any oral, written or gestured language that willfully includes disparaging and derogatory terms to			

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	05/09/2017

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
	residents...Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment..." The policy did not indicate alleged incidents of abuse should be reported to the State Agency. 3.1-28(a)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.			
	Based on observation, record review, and interview, the facility failed to promote 2 residents' dignity while dining during 1 of 1 random observation. (Residents 26 and 41) Findings include: a. The clinical record of Resident 41 was reviewed on 5/4/17 at 9:40 a.m.	F 0241	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Aide that referred to a clothing protector as a "bib" was immediately in serviced. **Other residents having the potential to be affected by the**	06/08/2017

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	05/09/2017

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
	Diagnoses for the resident included, but were not limited to, paralysis on one side and major depressive disorder. A quarterly Minimum Data Set assessment, dated 4/4/17, indicated Resident 41 was cognitively independent in his ability to make decisions. On 5/1/17 at 12:21 p.m., CNA (Certified Nursing Assistant) #1 asked Resident 41 if he would like to use a "bib" while eating lunch. b. The clinical record of Resident 26 was reviewed on 5/9/17 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, quadriplegia (paralysis of both arms and legs) and anxiety disorder. A quarterly Minimum Data Set assessment, dated 4/13/17, indicated Resident 26 was cognitively independent in his ability to make decisions. On 5/1/17 at at 12:20 p.m., Certified Nursing Assistant (CNA) #1 asked Resident 26 if he would like to use a "bib" while eating lunch. On 5/9/17 at 11:00 a.m., CNA #1 indicated she called the clothing protectors used by the facility, "bibs, I'm from the old school."		**same practice will be identified and the corrective actions taken are as follows;** All staff in serviced on use of terms such as “bib” as being inappropriate and in serviced on correct terminology. **The measures put into place and the systemic changes made are as follows:** DNS/Designee will ask staff daily what the proper terms for resident equipment and clothing. **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 will continue with monthly all staff in service where we will continue to educate staff on proper terminology that promotes dignity. Dept Head/Designee will attend 1 meal daily to monitor for appropriate use of terminology that promotes dignity. These audits will be conducted daily x60 days, then 3x weekly x60 days, then weekly x60 days. **Tracking record/audit form will be maintained in DNS office.**	

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	05/09/2017

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 5/9/17 at 10:23 a.m., the Director of Nursing provided a policy dated 2/2/17, titled, "Dignity," and indicated it was the policy currently used by the facility. The policy indicated, "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect...Treating residents with dignity and respect maintains and enhances each resident's self worth and improves his or her psychosocial well-being and quality of life... staff will promote the following types of staff interactions with residents, which maintain their dignity:...Promoting independence and dignity in dining..." 3.1-3(t)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident’s status. (h) Coordination A registered nurse must conduct or			

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	05/09/2017

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
	coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			
	Based on record review and interview, the facility failed to ensure a Minimum Data Set assessment was coded accurately for a resident who experienced significant weight loss, for 1 of 3 residents who met the criteria for review of nutrition. Findings include:	F 0278	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** MDS was coded incorrectly on a yes/no weight loss MDS question. The resident did in fact have a weight loss and it was coded as No in MDS Quarterly assessment. The MDS question	06/08/2017

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	05/09/2017

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 of Resident 4 was reviewed on 5/4/17 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease and kidney disease. On 9/27/17, Resident 4's weight was documented as 169. On 3/22/17 and 3/29/17, the residents weights were both documented as 149. This is an 11.8% weight loss in 180 days (6 months). Review of a quarterly Minimum Data Set (MDS) assessment dated 3/29/17, Section K0300, indicated Resident 4 had not experienced a weight loss of 10% or more in the previous 6 months. It was signed by the MDS Coordinator, certifying the accuracy of the resident assessment information for Section K. On 5/5/17 at 3:30 p.m. the Director of Nursing indicated Section K0300 of the MDS dated 3/29/17 for Resident 4, regarding a 10% or more weight loss in last 6 months, had been coded incorrectly. It should have been coded, "2. Yes, not on a physician-prescribed weight loss regime." 3.1-31(d)		was corrected and resubmitted during annual survey at time of discovery. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All residents identified with a significant weight loss by RD will be coded correctly in the MDS. **The measures put into place and the systemic changes made are as follows:** RNAC/Designee will monitor all significant weight loss in the MDS correctly. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** RNAC/Designee will audit all MDS prior to submission to ensure questions are answered appropriately. **Tracking record/audit form will be maintained in DNS office to ensure any allegations of abuse are reported to state in a timely manner.** **DNS/ED will report any findings**	

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	05/09/2017

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
			of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to ensure skin integrity reports were acted upon for 1 of 3 residents reviewed for pressure ulcers. (Resident 9) Findings include:	F 0314	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Resident identified in annual survey is no longer a resident in the facility. **Other residents having the potential to be affected by the same practice will be identified**	06/08/2017

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	05/09/2017

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 05/03/2017 1:08 p.m., Resident 9's clinical record was reviewed. Diagnosis included but not limited to: sacral spina bifida. Care plan, dated 01/26/2017 indicated Focus: Pressure ulcer: Resident 9 is at risk due to assistance required in bed mobility, and bowel incontinence. Goal: Skin will remain intact. Interventions included but were not limited to: complete Braden scale per Living Center Policy. Provide pressure reduction/relieving mattress. Referral to therapy. Turning and repositioning every two hours. Braden Scale for Predicting Pressure Sore Risk dated 3/31/2017, indicated Resident 9's total score was 17 (at risk for pressure ulcers). Medication Administration Record (MAR) dated 04/1/2017 - 4/30/2017, indicated no skin issues. Treatment Administration Record (TAR) dated 04/01/2017 - 4/30/2017, indicated no skin issues. Resident Shower Sheet / Skin Concern Documentation dated 4/25/2017, 4/22/2017, 4/15/2017, 4/4/2017, and 4/1/2017, indicated Resident 9 had		**and the corrective actions taken are as follows;** Facility skin audit completed and no other residents were affected by this deficient practice. No new or worsening skin conditions identified. **The measures put into place and the systemic changes made are as follows:** All nursing staff in serviced on Braden Scale, Weekly Skin assessments and Weekly Wound Assessments. **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 will continue to monitor weekly skin assessments. DNS/Designee will continue to monitor/audit weekly wound UDA's. DNS/Designee will review all shower sheets to ensure new skin concerns are reported to MD and intervention put into place. **Tracking record/audit form will be maintained in DNS office to ensure any allegations of abuse are reported to state in a**	

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	05/09/2017

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
	redness on her buttocks. Resident Shower Sheet / Skin Concern Documentation dated 4/18/2017, indicated redness and an open area on her buttocks. Skin assessment dated 4/18/2017, indicated Resident 9 "skin intact." No weekly skin assessment noted for 4/25/2017 or upon discharge. The Clinical Record lacked documentation to indicate the facility acted upon the skin condition reports which indicated skin injury (redness/open area). The Clinical Record lacked documentation of Physician notification. General Nurses Note dated 4/27/17, indicated Resident 9 was discharged from the facility to a group home, no skin assessment found in the nurses note. Care Plan, dated 04/26/16 indicated Focus: I Resident 9 have a physical functioning deficit related to: Self care impairment. Goal: included but not limited to inspect skin with care. Report reddened areas, rashes, bruising or open areas to the charge nurse.		**timely manner.** Audit x5 days weekly for x 60 days, audit x4days weekly x60 days, audit x3 days weekly for 60 days, audit x2 days weekly for 60 days, audit x1 weekly x60 days. **DNS/ED will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.**	

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	05/09/2017

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 5/9/2017 at 9:15 a.m., the DON provided a copy of Pressure Ulcer Risk Identification/Prevention Diagram (undated). The diagram indicated: "...change of condition, complete clinical Health Status 1. Skin assessment to be 1st section completed. 2. Compare assessment findings to risk factors on IPOC [initial plan of care]. Skin risk factors present? Yes: Is pressure ulcer present? Yes: Pressure ulcer identified from admission skin assessment/weekly skin assessment/observation. Implement resident specific interventions immediately: Specialty mattress/pressure reduction mattress on bed. Pressure reduction cushion in wheel chair. Treatment as ordered individualized repositioning. Plan of care/communication: initiate IPOC and place individual resident interventions and mark problem/risk factors. Notify family and document notification. Notify: Dietary, Activities and Social Services." On 5/4/2017 at 3:44 p.m., the DON provided a policy dated 1/26/2017, titled: Weekly Skin Review User Defined Assessments (UDA), and also indicated it was the current policy being used by the facility. "Policy Statement: A Weekly Skin Review UDA will be completed weekly on all residents and patients to			

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	05/09/2017

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
	check for any new skin issues not previously identified. ... This Policy Applies To: Licensed Nursing Staff. ...3. Complete the assessment on the date that it is due. Steps for Completion: ...The "Skin Intact" box is checked only when there are no skin alterations identified. ...If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. ...Medical Director (MD)/Nurse Practitioner (NP) are to be notified of any skin alteration, as well as the resident/patient, and his/her responsible party. ...Care Plans are to be updated with new interventions, and Certified Nursing Assistant (CNA) care sheets updated as indicated." The DON was unable to locate a skin assessment completed after 4/18/2017, by the end of the survey. 3.1-40(a)(1)			
F 0431 SS=E Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and			

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	05/09/2017

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

emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(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

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	05/09/2017

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
	authorized personnel to have access to the keys. (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, record review, and interview, the facility failed to ensure an account of all controlled drugs was maintained in 7 of 7 hall medication carts. Findings include: On 5/9/17 at 11:15 a.m., the the May, 2017, Narcotic Count Sheets (used by staff at the end/beginning of each shift to account for all controlled substances) for 7 of 7 medication carts were reviewed. The sheets contained a space for the outgoing nurse and incoming nurse to sign once they had ensured the narcotic count was accurate. The following dates did not have signatures verifying the accuracy of the narcotic count for May 1 - 8, 2017: A Hall: Short Cart:	F 0431	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Narcotic count books were signed and updated to compliance during survey at time of identified deficient practice. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All Narcotic count books audited for al signatures. **The measures put into place and the systemic changes made are as follows:** All nursing staff in serviced on signing in and out narcotic shift to shift count. **These corrective actions will**	06/08/2017

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	05/09/2017

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
	1st shift (7:00 a.m. - 3:00 p.m.) May 4 and 6, incoming; 2nd shift (3:00 p.m. - 11:00 p.m.) May 3, incoming; 1, 3, 4, 5, 6, 7, and 8 outgoing 3rd shift (11:00 p.m. to 7:00 a.m.) no signatures May 1 - 8 incoming nor outgoing Center Cart: 1st shift May 1, 6, 7 incoming and outgoing 2nd shift 11:00 p.m. May 1, 6, 7, incoming; May 1 - 8 outgoing; 3rd shift 7:00 a.m. May 1 - 8 no signatures incoming or outgoing Right Long Cart: 1st shift May 6,7 incoming and outgoing 2nd shift 11:00 p.m.: May 6.7 incoming and outgoing 3rd shift 7:00 a.m.: May 1 - 8 no signatures incoming or outgoing Left Long Cart: 1st shift May 4 incoming and outgoing, May 6 incoming 2nd shift May 1,3,4 incoming, May 1, 3, 4, 5 6, 7, 8 outgoing 3rd shift May 1 - 8 no signatures incoming or outgoing B Hall: Right Cart: 1st shift May 2, 3, 7, 8 incoming, May 3,		**be monitored and a quality assurance program implemented to ensure the deficient practice will not reoccur per the following:** DNS/Designee will monitor narcotic count books daily to ensure proper signatures are in place. **Tracking record/audit form will be maintained in DNS office.** **DNS/ED will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.**	

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	05/09/2017

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, 8 outgoing 2nd shift May 3, 5, 6 incoming, May 6 outgoing 3rd shift May 1 outgoing, May 7 incoming and outgoing Left Cart 1st shift May 2, 6, 7, 8 incoming and outgoing 2nd shift May 3, 6, 7 incoming, May 6 outgoing 3rd shift May 6, 7 incoming and outgoing Center Cart There were no signatures on any of the days or shifts Short Cart 1st shift May 3, 4, 5, 8 incoming and outgoing 2nd shift May 1, 4, 5, 7 incoming and outgoing, May 2, 6 outgoing 3rd shift May 1, 6 incoming and outgoing On 5/9/17 at 11:25 a.m., Licensed Practical Nurse #3 indicated the nurses are always supposed to count the narcotics between shifts and sign the Narcotic Count Sheets indicated accuracy of the count. On 5/9/17 at 11:32 a.m. Registered Nurse			

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	05/09/2017

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
	#4 indicated the nurses are supposed to count the narcotics between shifts and sign the Narcotic Count Sheets On 5/9/17 at 2:00 p.m. the Director of Nursing provided a policy dated August 2014, titled Controlled Substance Storage, and indicated it was the policy currently used by the facility. The policy indicated, "At each shift change, or when keys are transferred, a physical inventory of all controlled substances...is conducted by two licensed nurses and is documented." 3.1-25(n)			
F 0465 SS=E Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

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	05/09/2017

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
	(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.			
	Based on observation, interview, and record review, the facility failed to ensure a comfortable and sanitary environment for residents for 9 of 9 resident shared bathrooms observed affecting 13 residents (Resident 26, 29, 34, 39, 41, 55, 57, 60, 62, 82, 86, 97, and 120). Findings include: On 5/2/17 the following was observed: 11:11 a.m., in Resident 39 and 57's bathroom, above and to the left of the toilet tank a small 3 inch hole was noted in the wall. Also, a piece of the wallpaper (4 inches wide and 8 inches in length) on the wall to the left of the sink was missing. 2:32 p.m., in Resident 41 and 97's bathroom, above and to the right of the toilet tank a small 3 inch hole was noted in the wall; 4 very small screw holes were noted on the wall to the right side of the sink; and the window lacked any window covering.	F 0465	**The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Bathrooms that were identified with concerns on environmental rounds are being repaired by contracted service providers. **Other residents having the potential to be affected by the same practice will be identified and the corrective actions taken are as follows;** All bathrooms in facility will be reviewed and areas of concerns will be repaired and remodeled. **The measures put into place and the systemic changes made are as follows:** The bathrooms that need repair have been identified. The facility has contracted with Firestorm Restoration to repair and remodel the bathrooms identified with an excepted completion date of June 23. **These corrective actions will be monitored and a quality assurance program**	06/08/2017

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	05/09/2017

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
	2:33 p.m., in Resident 86's bathroom, the baseboard was missing; the wall above the toilet tank contained a 6 inch area where the wall was repaired but not painted; and the wood work around bathroom door was damaged. 2:42 p.m., in Resident 120's bathroom, under the towel dispenser a 3 inch hole was noted on the wall and the bathroom window covering contained white smears on the green curtains. On 5/3/17 the following was observed: 10:13 a.m., in Resident 29 and 60's bathroom, above the toilet tank area contained a 6 inch area where the wall was repaired but not painted. 10:15 a.m., in Resident 26's bathroom, above the toilet tank area and on the side wall contained 6 inch areas where the wall was repaired but not painted and the transition strip between the bathroom and the resident room was missing. 10:17 a.m., in Resident 34's bathroom, above and to the right of the toilet tank a small 2 inch hole was noted in the wall. 10:19 a.m., in Resident 82's bathroom,		**implemented to ensure the deficient practice will not reoccur per the following:** Maintenance Supervisor/Designee will monitor all bathrooms in facility on weekly rounds and issues identified will be logged and corrected. **Tracking record/audit form will be maintained in DNS office** **DNS/ED/Maintenance Director will report any findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.**	

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	05/09/2017

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 baseboard was missing under the sink and toilet area and the same wall contained 6 inch areas that were repaired but not painted. 10:21 a.m., in Resident 55 and 62's bathroom, above and to the right of the toilet tank a small 2 inch hole was noted; the bathroom walls contained areas where the walls were repaired but not painted; and there were no baseboards in the bathroom. On 5/4/17 at 1:52 p.m., an environmental tour was conducted with the Maintenance Supervisor (MS), Housekeeping Supervisor (HS), and Administrator (Adm). The tour included 9 resident bathrooms for 13 residents (Resident 26, 29, 34, 39, 41, 55, 57, 60, 62, 82, 86, 97, and 120). During the tour, the same concerns (as listed above) were observed. On 5/4/17 at 1:52 p.m., during an interview, the MS indicated the facility began a water pipeline project which involved 30 resident bathrooms and that is why the 9 rooms observed during the tour contained either holes or unpainted wall repairs near the toilet tank area. The pipeline project began 6 months ago and was completed 5 weeks ago. On 5/4/17 at 1:52 p.m., the HS indicated			

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	05/09/2017

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
	she was unaware Resident 120's green curtain contained white smears and Resident 41 and 97 windows were missing the curtain rod which prevented a curtain from being hung. It was unclear how long the window was without a window covering. On 5/9/17 at 9:30 a.m., the Director of Nurses provided the Housekeeping inservice-Complete Room Cleaning policy dated 1/1/2000, and indicated the policy was the one currently being used by the facility. The policy stated on page 5-15, "Windows-clean window tracks and check curtains. Report any soiled or damaged curtains to housekeeping supervisor." 3.1-19(f)(5)			