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	06/23/2016

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 15, 16, 17, 18, 19, 20, 21, 22, and 23, 2016. Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census bed type: SNF/NF: 75 Total: 75 Census payor type: Medicare: 11 Medicaid: 59 Other: 5 Total: 75 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on June 29, 2016.	F 0000		

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

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F 0159 SS=E Bldg. 00	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on interview and record review, the facility failed to ensure residents had on going access to their personal fund accounts for 3 of 4 residents with a facility personal funds account. Findings include: a. During an interview on 6/16/16 at 10:42 a.m., Resident #10 indicated that she could not always withdraw money from her personal fund account, Monday through Friday or on weekends, because the facility runs out of money. Then you have to wait one or two days before the facility gets more money. b. During an interview on 6/17/16 at 10:09 a.m., Resident #07 indicated he could not always withdraw money from his personal fund account. The money deposits into his account on the first day of the month. He can not get any money out until the second or third. Then he can only withdrawal thirty dollars ($30.00). Then he can not get additional money until the eighth or ninth of the month.	F 0159	**All resident have the potential to be affected by this deficient practice** Residentinterviews indicated that they were unable to access resident funds at specifictimes of the month and in the amount of money they requested. **Other residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** No other residents interviewed by facility staff had any issues with accessingtheir funds. **The measures put into place and the systemic changes madeto ensure that this deficient practice does not recur are as follows:** Business Office Manager or designee will educate residents on facilitybanking policy and procedures. Business officer Manager or	07/19/2016

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	The facility tells him they do not have the money, all the money does not come in at one time. c. During an interview on 6/17/16 at 10:09 a.m., Resident #58 indicated she can not always get her money, she has to wait for a couple of days. In an interview on 6/21/16 at 3:30 p.m., the Administrator indicated, this facility is given an allotment of $300 of cash to keep on hand for residents requesting money from their account. As the money is dispersed, the facility must contact the corporate office to replenish those cash amounts back into the facility account. It usually takes 1 to 2 business days to see those amounts available for distribution. It is normal for our allotment of $300 to be depleted well before the end of day each day. Most residents withdraw an average of $40 at a time which creates a challenge meeting our resident daily needs. At times, some residents have not had immediate access to their account due to this challenge. To mitigate this challenge, the facility has asked our corporate office to increase the amount of cash on hand to help meet the needs of our residents. I, the Administrator, have been informed that at this time, there will be no increase in the amount of cash on hand. However, our case is being		designee will educate residents on Governmentand State days of the month that affect deposits. Facility has received an increase to the amount of $800 to accommodate residentfund needs. These corrections will be addressed in resident council on 7/12/2016 **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following:** Any concerns from a resident will be reviewedand BOM or ED will be contacted as needed. A Tracking record/audit form will be maintainedin Business Office to ensure all resident fund requests are monitored and dispersed in accordance to state policy. That tracking tool will be reviewed daily x30 days by the ED or designee If no patterns or trends identified then review will have weekly x 30 days, then as needed **BOM/Designee will reportfindings of any resident fund concerns to monthly QA meetings for 6 months, anypatterns or trends will have an plan of correction plan written and**	

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	reviewed. 3.1-6(f)(1)		**interventionsimplemented. Review will continue until trends are resolved**	
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in			

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	assessment. Based on record review and interview, the facility failed to ensure a comprehensive assessment accurately assessed medications for 1 of 5 residents reviewed for medications. (Resident #7) Findings include: The clinical record review for Resident #7 was completed on 6/20/16 at 9:21 a.m. Diagnoses included, but were not limited to, depressive disorder and hypertension. A Minimum Data Set (MDS) assessment dated 9/30/16, assessed Resident #7 as receiving an antianxiety medication for 7 of 7 days during the assessment period. A review of Physician orders for Resident #7 between 9/1/15 and 9/30/15, lacked an order for an antianxiety medication. A review of the Medication Administration Record (MAR) for Resident #7 between 9/1/15 and 9/30/15, lacked documentation indicating an antianxiety medication was administered to Resident #7. During an interview on 6/22/16 at 12:55 p.m., the MDS Coordinator indicated Resident #7 did not have an antianxiety	F 0272	**This deficient practice hasthe potential to affect all residents residing in facility.** All Other resident's MDS/RAI were reviewed by facility staff. Noother errors identified. **The measures put into place and the systemic changes madeto ensure that this deficient practice does not recur are as follows:** RNAC/MDS Coor/Designee willreview medication coding on MDS with another nurse to ensure proper coding andno error on medication received for review periods. RNAC educated on medicationclasses and coding. **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following:** All medication class questions on MDS will beentered by RNAC/Designee and reviewed with DNS/Designee to ensure correctcoding prior to submitting MDS. Will audit 5x weekly for 30 days. If no trendsidentified, will continue audit x3 days weekly for 30 days. If no trendsidentified again, will audit as needed. **Tracking record/audit formwill be maintained in DNS/RNAC office to ensure complete audits as required. RNAC/Designee will reportfindings of any MDS medication errors to monthly**	07/11/2016

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	medication ordered in September 2015, and the MDS assessment dated 9/30/15, was coded incorrectly. 3.1-31(d)		**QA meetings for 6 months, anypatterns or trends will have an action plan written and interventionsimplemented. **addendum - Correct action taken for resident #7--MDS was corrected, submitted, and accepted for resident #7**	
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to ensure a care plan was developed which described services to be provided for a resident with bilateral knee contractures resident	F 0279	**The corrective actionsaccomplished for those residents found to have been affected by the deficientpractice are as follows:** R54 care plan was updated to reflectcontractures and ROM needs. **Other**	07/19/2016

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	for 1 of 1 resident who met the criteria for review of range of motion services. (Resident #54) Findings include: 1. The clinical record of Resident #54 was reviewed on 6/22/16 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, stroke and muscle weakness. An annual Minimum Data Set assessment, dated 5/26/16, indicated Resident #54 had a functional limitation in range of motion (ROM) to his bilateral lower extremities (BLE). An observation of Resident #54 on 6/16/16 at 11:43 a.m. indicated Resident #54's knees appeared to be contracted bilaterally. A Physical Therapy Progress & Discharge Summary, dated 6/17/16, indicated Resident #54 had a left knee contracture, and limited range of motion in his right knee. A care plan for functional limitation in range of motion was not found in the resident's record. On 6/23/16 at 9:30 a.m., the Director of		**residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** Resident reviewed to identify residents withcontractures ensure the contracture was noted. Resident with contractures hadCP updated and intervention appropriate. **The measures put into placeand the systemic changes made to ensure that this deficient practice does notrecur are as follows:** Therapy will report daily (if applicable) to the DNS/Designee any resident noted to have a contracture to ensure a care plan is initiated. **These corrective actionswill be monitored and a quality assurance program implemented to ensure the deficientpractice will not recur per the following:** Audit form will be maintained in Nursingoffice to ensure any resident with a contracture has a care plan and ROM ifindicated. Audits will be conducted x5 days weekly for 30 days. If no trendsidentified will audit weekly indefinitely. **DNS/Designee will reportfindings of audits to monthly QA meetings for 6 months, any patterns or trendswill have an action plan written and interventions implemented.**	

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	Nursing indicated a limited range of motion care plan had not been created for Resident #54. 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a resident's pain management care plan was followed for 1 of 5 residents reviewed pain management care in accordance with their plan of care. (Resident #100) Findings include: The closed clinical record of Resident #100 was reviewed on 6/20/16 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, chronic pain and bile duct cancer. Resident #100 was admitted to the facility on 2/17/16, and discharged to the hospital on 3/3/16.	F 0282	**The corrective actionsaccomplished for those residents found to have been affected by the deficientpractice are as follows:** R100 hasdischarged facility. **Other residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** All Facility resident care plans reviewed forPain Management CP and updated if appropriate. **The measures put into place and the systemic changes madeto ensure that this deficient practice does not**	07/19/2016

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	A physician's order, dated 2/17/16, indicated Resident #100 was to receive oxycodone 10 mg (milligrams) every 8 hours for 5 days. Oxycodone is a narcotic pain medication. A care plan for Resident #100, dated 2/18/16 and current through 6/2/16, indicated, "Needs pain management and monitoring related to recent gallbladder/cancer removal..." The goal for this care plan was, "Will maintain adequate level of comfort as evidenced by no s/sx [signs and symptoms] of unrelieved pain or distress, or verbalizing satisfaction with level of comfort." Another physician's order, dated 2/23/16, indicated Resident #100 could receive oxycodone 10 mg, 4 tablets, every 8 hours for 5 days. The Medication Administration Record (MAR) for February, 2016, indicated the oxycodone was scheduled to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A Controlled Substance Accountability Sheet indicated Resident #100 received her oxycodone every 8 hours as ordered, and the last dose was administered at 2:00 p.m. on 2/28/16. Review of Medication Administration Records for February, 2016, indicated a		**recur are as follows:** An audit tool was created to help monitor residents who have uncontrolledpain. DNS/Designee will audit pain careplans x5 days weekly for 30 days. If notrends identified then weekly monitoring will continue indefinitely. interventionsfor residents. **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following:** DNS Will audit x5 days weekly for 30 days. Ifno trends identified then weekly monitoring will continue indefinitely. Additionally,if residents are experiencing pain, those residents will be interviewed everyshift until pain in controlled. Nurse education has been completed with regardsto this. **DNS/Designee will reportfindings of audits to monthly QA meetings for 6 months, any patterns or trendswill have an action plan written and interventions implemented.**	

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	pain scale was used by the facility for Resident #100 to rate her pain, from level 1 to level 10. Level 10 was the worst pain. On 2/18/16 at 6:00 a.m., the resident had rated her pain at a level 8, and at 2:00 p.m., she rated her pain at level 7. A nurse's note, dated 2/29/16 at 12:39 a.m., indicated, "At around 10pm Res [resident] asked for pain pill, this author checked the order found out that the order for oxycontin [oxycodone] has ended tonight good for 5 days only, Res was upset stated, 'they give it to me this morning,' Res further saying, 'I taken it everyday,' this author offered a PRN [as needed] trazodone [an antidepressant] per MD [medical doctor] order for sleep instead, Res refused that she don't want to go to sleep when she's in pain, this author explain to Res that the pain pill order has ended today, and NP [nurse practitioner] will evaluate on Tuesday about the increase pain, Res unable to understand and told this author 'leave me alone,' this author left room." On 3/1/16 at 2:30 p.m., the nurse practitioner wrote an order for Resident#100 to receive oxycodone 10 mg every 4 hours as needed. Resident #100 was without oxycodone			

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	pain medication from 2:00 p.m. on 2/28/16 through 2/29/16, until new orders were written on 3/1/16. On 6/22/16 at 3:30 p.m., the DON provided a policy titled, "Pain Assessment and Management," and indicated it was the policy currently used by the facility. The policy indicated, "It is the policy of [name of facility] to promptly assess patient/resident pain levels and to provide relief of symptoms whenever feasible, using a patient/resident-centered and interdisciplinary approach." On 6/22/16 at 10:25 a.m., the Director of Nursing (DON) indicated she was unable to find any documentation which indicated the nurse who received Resident #100's complaints of pain, on 2/28/16 at 10:00 p.m., contacted a physician regarding pain relief for the resident. The DON indicated the nurse should have called the physician to report the resident's pain and that her pain medication order had expired. 3.1-35(g)(2)			

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F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary 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. Based on record review and interview, the facility failed to ensure a resident's pain was managed as indicated by their plan of care and facility policy, for 1 of 5 residents reviewed for pain management. (Resident #100) Findings include: The closed clinical record of Resident #100 was reviewed on 6/20/16 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, chronic pain and bile duct cancer. Resident #100 was admitted to the facility on 2/17/17 and discharged to the hospital on 3/3/16. A physician's order, dated 2/17/16, indicated Resident #100 was to receive oxycodone 10 mg (milligrams) every 8 hours for 5 days. Oxycodone is a narcotic pain medication.	F 0309	**The corrective actionsaccomplished for those residents found to have been affected by the deficientpractice are as follows:** R100 hasdischarged facility. **Other residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** Residents that require PRN or Scheduled painmedication have been interviewed to verify adequate pain control. No additionalconcerns noted. MD to review PRN pain medications todetermine need for scheduled medications. MD reviewed timed ordered pain medications toensure a plan for stop date. **The measures put into place and the systemic changes madeto ensure that this**	07/19/2016

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	A care plan for Resident #100, dated 2/18/16 and current through 6/2/16, indicated, "Needs pain management and monitoring related to recent gallbladder/cancer removal..." The goal for this care plan was, "Will maintain adequate level of comfort as evidenced by no s/sx [signs and symptoms] of unrelieved pain or distress, or verbalizing satisfaction with level of comfort." Another physician's order, dated 2/23/16, indicated Resident #100 could receive oxycodone 10 mg, 4 tablets, every 8 hours for 5 days. The Medication Administration Record (MAR) for February, 2016, indicated the oxycodone was scheduled to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A Controlled Substance Accountability Sheet indicated Resident #100 received her oxycodone every 8 hours as ordered, and the last dose was administered at 2:00 p.m. on 2/28/16. Review of Medication Administration Records for February, 2016, indicated a pain scale was used by the facility for Resident #100 to rate her pain, from level 1 to level 10. Level 10 was the worst pain. On 2/28/16 at 6:00 a.m., the resident had rated her pain at a level 8,		**deficient practice does not recur are as follows:** Unit Managers/Charge nurses will report in clinical start up daily and changes in pain reports and painmedication order changes. **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following** Unit Managers/Charge nurses will report in clinical start up daily andchanges in pain reports and pain medication order changes 5x weekly x30 daysand if no trends identified will audit weekly indefinitely. **DNS/Designee will reportfindings of audits to monthly QA meetings for 6 months, any patterns or trendswill have an action plan written and interventions implemented.**	

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	and at 2:00 p.m. she rated her pain at level 7. A nurse's note, dated 2/29/16 at 12:39 a.m., indicated, "At around 10pm [on 2/28/16] Res [resident] asked for pain pill, this author checked the order found out that the order for oxycontin [oxycodone] has ended tonight good for 5 days only, Res was upset stated, 'they give it to me this morning,' Res further saying, 'I taken it everyday,' this author offered a PRN [as needed] trazodone [an antidepressant] per MD [medical doctor] order for sleep instead, Res refused that she don't want to go to sleep when she's in pain, this author explain to Res that the pain pill order has ended today, and NP [nurse practitioner] will evaluate on Tuesday about the increase pain, Res unable to understand and told this author 'leave me alone,' this author left room." On 3/1/16 at 2:30 p.m., the nurse practitioner wrote an order for Resident #100 to receive oxycodone 10 mg every 4 hours as needed. Resident #100 was without oxycodone pain medication from 10:00 p.m. on 2/28/16 through 2/29/16, until new orders were written on 3/1/16 at 2:30 p.m. On 6/22/16 at 3:30 p.m., the DON			

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	provided a policy titled, "Pain Assessment and Management," and indicated it was the policy currently used by the facility. The policy indicated, "It is the policy of [name of facility] to promptly assess patient/resident pain levels and to provide relief of symptoms whenever feasible, using a patient/resident-centered and interdisciplinary approach." On 6/22/16 at 10:25 a.m., the Director of Nursing (DON) indicated she was unable to find any documentation which indicated the nurse who received Resident #100's complaints of pain, on 2/28/16 at 10:00 p.m., contacted a physician regarding pain relief for the resident. The DON indicated the nurse should have called the physician to report the resident's pain and that her pain medication order had expired. 3.1-37(a)			
F 0311 SS=E Bldg. 00	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, record review, and interview, the facility failed to ensure a	F 0311	**The corrective actionsaccomplished for those residents found to have been**	07/19/2016

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	resident with bilateral knee contractures received restorative services to prevent further decline for 1 of 1 residents who met the criteria for review of range of motion services (Resident #54), and failed to provide restorative services for 3 residents recently discharged from occupational therapy (Resident #18 , #5, and #16). Findings include: 1. The clinical record of Resident #54 was reviewed on 6/22/16 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, stroke and muscle weakness. An annual Minimum Data Set assessment, dated 5/26/16, indicated Resident #54 had a functional limitation in range of motion (ROM) to his bilateral (both) lower extremities (BLE). An observation of Resident #54 on 6/16/16 at 11:43 a.m., indicated Resident #54's knees appeared to be contracted bilaterally. A contracture is a condition of fixed high resistance to passive stretch of a muscle. A Physical Therapy Progress & Discharge Summary, dated 6/17/16,		**affected by the deficientpractice are as follows:** R54 wasevaluated by therapy to determine need for ROM services. **Other residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** All residentsreviewed and no other residents were identified as affected. Residents will bereviewed for ROM/PROM after being discharged from therapy services. **The measures put into place and the systemic changes madeto ensure that this deficient practice does not recur are as follows:** Resident withPROM/ROM need will be added to C.N.A care sheets. IDT Team willmonitor using audit tool any residents being discharged from services for ROM/PROM need. Nursing staffeducated on PROM/ROM being provided during care for those who require it. **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following:** All residentson therapy caseload will be reviewed by IDT team and PROM/ROM will beinitiated after discharge. Audit will be x5 days weekly for 30 daysand if no trends identified, IDT team will audit and monitor daily x5	

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	indicated Resident #54 had a left knee contracture and limited range of motion in his right knee. The resident was treated by Physical Therapy starting 5/19/16. Goals were to improve range of motion to both knees to enable the resident to transfer from his wheelchair with moderate assistance of 2 staff. At the start of therapy, staff was using a lift to transfer the resident. The discharge summary, dated 6/17/16, indicated Resident #54 was able to transfer with maximum assistance of staff. The resident had demonstrated increased tolerance with ROM and BLE and was able to tolerate BLE omnicycle for continued ROM and strengthening activity. Omnicycle is a motorized rehabilitation system for upper and lower extremities. The discharge summary indicated the resident would remain in the facility with a Functional Maintenance Program (FMP)/Restorative Nursing Program (RNP). On 6/22/16 at 12:23 p.m., Certified Nursing Assistant (CNA) #10, who was caring for Resident #54 that day, indicated she had no special functional maintenance, restorative nursing assignments for the resident. She produced her CNA assignment sheet and		daysweekly for 30 days during clinical start up. **DNS/Designee will reportfindings of audits to monthly QA meetings for 6 months, any patterns or trendswill have an action plan written and interventions implemented.** ****Addendum -- Residents #**18, #5 and #16 Care Plans were updated and Range of Motion added to CNA sheets	

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	accessed the Kiosk for the resident. No maintenance exercises to maintain the resident's BLE ROM were observed documented as needing to be done. On 6/23/16 at 3:30 p.m., the Physical Therapy manager indicated he had contacted Resident #54's therapist. The resident's therapist told the manager a Restorative Nursing Sheet had not been filled out for the resident. 2. The clinical record of Resident #18 was reviewed on 6/23/16 at 3:45 p.m. Diagnoses for the resident included, but were not limited to, Parkinson's disease and dementia. A Therapy Referral to Restorative Nursing form, dated 5/31/16, indicated Resident #18 had a history of debility and potential for functional decline, and would benefit from the restorative nursing program to maintain gain made during Occupational Therapy intervention. The goal was the resident would participate in RNP (Restorative Nursing Program) 3-5 times a week. Recommendations included the omnicycle for 20 minutes and bicep curls with a therabar, 2 sets of 20 repetitions. These therapy recommendations were not placed on the CNA assignment sheet or in the computer Kiosk. On 6/23/16 at			

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	4:10, CNA #10 indicated she was not aware Resident #18 was supposed to be receiving these services. 3. The clinical record of Resident #5 was reviewed on 6/23/16 at 3:55 p.m. Diagnoses for the resident included, but were not limited to, arthritis and dementia. A Therapy Referral to Restorative Nursing form, dated 6/8/16, indicated the Resident #5 was at risk for decline and would benefit from a restorative nursing program to maintain gains made in therapy. The goal was 3-5 times per week participation. Recommendations included the omnicycle times 15 minutes, the therabar for bicep curls, side to side and balloon bat, 3 sets times 15 repetitions. These therapy recommendations were not placed on the CNA assignment sheet or in the computer Kiosk. On 6/23/16 at 4:10 p.m., CNA #10 indicated she was not aware Resident #5 was supposed to be receiving these services. 4. The clinical record of Resident #16 was reviewed on 6/23/16 at 4:00 p.m. Diagnoses for the resident included, but were not limited to, stroke and right side paralysis.			

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	A Therapy Referral to Restorative Nursing, dated 6/2/16, indicated the resident had a history of functional decline and would benefit from a RNP (Restorative Nursing Program) to maintain gains made from therapy intervention. The goal was participation in RNP 3-5x per week. Recommendations included, omnicycle for 20 minutes for arms and legs, left upper extremity using 2# wrist weight biceps curls across body and out to the side, right upper extremity biceps curls, for 3 sets of 15 repetitions. These therapy recommendations were not placed on the CNA assignment sheet or in the computer Kiosk. On 6/23/16 at 3:40 p.m., CNA #2 indicated she was not aware Resident #16 was supposed to be receiving these services. On 6/23/16 at 3:00 p.m., the DON indicated, when a resident is finished with Physical Therapy, but continues to need specialized exercises to prevent further decline in range of motion, the physical therapist will fill out a Restorative Nursing Sheet indicating what type of exercises the nursing staff need to do with the resident. The DON indicated, at this time, the facility does not have a Restorative Nursing Program, but they do have a Functional			

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	Maintenance Program. The recommendations of the therapist would be included in the daily care of the resident as evidenced by instructions on the CNA's daily assignment sheet, and on the computer Kiosk, which the CNA's consult routinely throughout the day. 3.1-38(a)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was properly dated and resident drinks were covered as indicated by facility policy and procedure. Findings include: a. On 6/15/16 at 7:43 a.m., 6 cartons of vanilla Sysco shakes were observed in wing A nourishment refrigerator unthawed and undated. Wing A nourishment refrigerator was also observed to have 1 Nectar Thickened 2% milk opened and undated.	F 0371	The facility will store,prepare, distribute and serve food under sanitary conditions. 1.Undated houseshakes in the nourishment pantry refrigerators were discarded on 6/22/16. 2.Nursing &Dietary Staff were in-serviced on food storage and use-by-dates on: 7/15/2016 3.Cold food storageprocedures; labeling and dating will be monitored on the nourishment	07/19/2016

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	b. During an observation on 6/22/16 at 3:00 p.m., wing B nourishment refrigerator was noted to contain 9 cartons of Sysco shakes unthawed and undated, 1 open 20 ounce bottle of green tea with no label and undated, and a salad covered with plastic wrap with no label. c. During an observation on 6/23/16 at 3:55 p.m., 7 glasses and 1 pitcher, all containing orange liquid were observed uncovered on top of a cart in the hallway. A review of a Sysco shake carton indicated, "Store frozen, thaw under refrigeration. Keep refrigerated, use within 14 days after thawing." During an interview on 6/23/16 at 4:00 p.m., Dietary Aide #4 indicated resident drinks should be covered when on carts in the hallway. On 6/22/16 at 4:21 p.m., the Administrator provided a policy last revised on 2/29/16, titled Storage of Refrigerated Foods, and indicated it was the current policy used by the facility. The policy indicated, "...Label and note pull date with "use by" date on all food items when removing from freezer...." The policy lacked information regarding covering resident drinks.		pantriesby the Dietary Services Manager, Director of Nursing (or designee when themanager is absent) at least one time per day x 5 per week for 30 days and then 3 x per week for 30day. Then if no trends identified, monitoring will happen Prn. sanitationmonitoring checklist will be completed during rounds and kept by the DiningManager with a copy provided to the Executive Director. 4.The DiningServices Manager will report any trends of deficiencies found to the QAPICommittee on a monthly basis for at least 3 months and for any recommendationsand resolutions.	

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	3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and			

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	transport linens so as to prevent the spread of infection. Based on record review, interview, and observation, the facility failed to ensure soiled linen was properly bagged before leaving residents' room in accordance with current facility policy. Findings include: a. On 6/15/2016 at 7:40 a.m., observed a pile of dirty linens (sheets, boxers, and pillow case) noted in hallway next to room 12. Foul odor noted in area. No staff observed in area. b. On 6/15/2016 at 7:45 a.m., observed towel and wash rag on the floor in room #18. No staff were observed in area. During an interview on 6/19/2016 at 10:00 a.m., Certified Nursing Assistant (CNA) #1 indicated dirty linens are bagged prior to leaving residents room then transported to laundry room. During an interview on 6/19/2016 at 10:10 a.m., CNA #2 indicated all dirty linens are bagged before leaving residents room. On 6/21/2016 at 11:48 a.m., the Executive Director provided Bloodborne Pathogens Exposure Control Plan, last	F 0441	**The corrective actionsaccomplished for those residents found to have been affected by the deficientpractice are as follows:** Facilitystaff observed carrying linen in common area without being properly bagged. **Other residents having thepotential to be affected by the same deficient practice will be identified andthe corrective actions taken are as follows:** No otherstaff observed carrying linen in hallway. **The measures put into place and the systemic changes madeto ensure that this deficient practice does not recur are as follows:** FacilityStaff educated on proper procedure for linen removal from residents room perpolicy. **These corrective actionswill be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following:** DNS/Designee will audit facility staff aftercare is provided and watch removal of linen from room and ensure properdisposal. Auditx5 days weekly x30 days and if no trends identified will audit x3 days weeklyx30 days. If no trends identified will audit PRN. **DNS/Designee will report findings of audits to monthly QA meetings for 6**	07/19/2016

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	revised on 4/14/15, and indicated currently being used by the facility, "Laundry and Linens. Bagging: All soiled linens must be BAGGED AT THE LOCATION WHERE THEY ARE USED, and shall not be sorted or rinsed in the location of use. Bags must be securely sealed before being removed from the room. Contaminated laundry will be placed and transported in bags or containers labeled or color-coded according to the standard. when a facility uses standard (universal) precautions in handling soiled laundry, alternating labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with standard (universal) precautions. Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage and/or leakage of fluids to the exterior." On 6/21/2016 at 10:00 a.m., the Assistant Director of Nursing provided Infection Control Program policy dated 12/1/2014, and indicated it is the policy currently being used. "Guideline Statement: An effective infection prevention and control program is necessary to control the spread of infections and/or outbreaks. Program and development and oversight: ....Developing and implementing appropriate infection control policies and		**months, any patterns or trends will have an action plan written and interventions implemented.** **Addendum --DNS/Designee will audit** DNS/Designee will audit facility staff aftercare is provided and watch removal of linen from room and ensure proper disposal. Audit on all shifts x 7 days for 30 days and if no trends identified will audit x3 days weekly x30 days. If no trends identified will audit PRN.	

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	procedures, and training staff on them. Components of an Infection Prevention and Control Program ....Education, including training in infection prevention and control practices, to ensure compliance with facility requirements as well as State and Federal regulation." 3.1-19(g)(1)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure that resident rooms were in good repair for 7 of 31 resident rooms. Findings include: a. During a stage 1 observation on 6/17/16 at 11:13 a.m., and an observation during environmental tour on 6/23/16 at 2:30 p.m., in resident room #15's bathroom, the wall was damaged, paint and paper missing, in an area of 4" by 6" located near the hand washing sink. b. During an environmental tour observation on 6/23/16 at 2:30 p.m., in	F 0465	All residents have the potential to be affected by this deficient practice. All resident room damages noted under this tag have been repaired. In addition other resident rooms have been inspected an placed on a plan to repair To ensure this deficient practice does not recurr, all rooms are scheduled to be inspected and repaired on a routine basis. Staff to be in serviced on reporting any damages to the Maintenance director or designee. ED/designee to review room repair/inspection schedule every business day, and inspect those rooms that were scheduled to be repaired on the previous day. Additionally, room	07/08/2016

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	06/23/2016

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

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	resident room #20's bathroom, the wall was damaged, paint and paper missing, in an area of 4" by 6" located near the hand washing sink. c. During a stage 1 observation on 6/17/16 at 11:13 a.m., and an observation during environmental tour on 6/23/16 at 2:30 p.m., in resident room #21, the door frame from the floor up 4 feet (ft) was scratched, marred, and had missing paint. d. During a stage 1 observation on 6/17/16 at 11:13 a.m., and an observation during environmental tour on 6/23/16 at 2:30 p.m., in resident room #23, located in the bathroom near the hand washing sink, dry wall exposed, and there were 2 quarter sized holes, and 2 smaller holes. Under the bathroom window above the baseboard, area was scuffed up, paint was missing and dry wall was exposed. There was wall damage under the sink above the baseboard. Outside of the bathroom door above the baseboard the wall was scratched, marred, and had missing paint. The wallpaper behind the nightstand was ripped and torn. e. During a stage 1 observation on 6/17/16 at 11:13 a.m., and an observation during environmental tour on 6/23/16 at 2:30 p.m., in resident room #32, near the head of the bed there was wall damage of		damage/repair inspections have been added to each department managers daily room inspection list. Concerns will be addressed during the management team's daily stand up meeting. Inspections are to be completed every day x 30, then 3 x weekly for 30 days, and 2 x weekly thereafter. The results of these audits will be presented at QA&A for three months to track for any trends. If any trends are identified audits will continue based on QA&A recommendations. If no trending identified the will be reviewed on prn basis.	

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	a hole in the wall approximately 2" X 1/2". The wooden chair rail going around the room was loose and hung crookedly. There were white spackling smears on the wall behind the bed, there were also 7 spackling smears on the wall at the bathroom entrance f. During an environmental observation tour on 6/23/16 at 2:30 p.m., in resident room #34, the wall located near the bathroom entrance, had 10 different size areas of dry wall mud work covering approximately 3' by 5', but work was not completed. Resident # indicated that the had been like for several days. g. During a stage 1 observation on 6/17/16 at 11:13 a.m., and an observation on environmental tour on 6/23/16 at 2:30 p.m., in resident room #37, the walls around the bed were marred and had missing paint. The environmental tour on 6/23/16 at 2:30 p.m., was conducted with the Administrator, Maintenance Supervisor, and Housekeeping Supervisor. At the end of environmental tour, the Administrator and Maintenance Supervisor indicated that they were in the process of remodeling some rooms and that they were aware of some day to day repairs that needed to be done, but have			

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	not yet got them completed 3.1-19(f)			