	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED - 02/21/2013	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVING CENTER	-INDIANAPOLIS		CHURCHMAN AVE NAPOLIS, IN 46203		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE COMPLET	TION
TAG =000000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	<u>.</u>
F000000	State Licensur included the Ir Complaint INC Substantiated related to the Survey dates: 15, 17, 18, 19 Facility number Provider number AIM number: Survey team: Marcy Smith, Leia Alley, RN (February 12, & 21, 2013) Patti Allen, BS (February 13, 21, 2013) Dinah Jones,	20121971 - No deficiencies allegations are cited. February 12, 13, 14, , 20, & 21, 2013. er: 000063 per: 155138 100266210 RN-TC I 13, 14, 15, 18, 19, 20, SW 14, 15, 17, 18, 19, 20 & RN 13, 14, & 15, 2013) ype:	F000000	Preparation, submission, implementation of the Pla Correction does not const an admission of or agreen with the facts and conclus set forth on the survey rep Our Plan of Correction is prepared and executed as means to continuously improve the quality of car to comply with all applicat state and federal regulato requirements.	an of titute nent sions port. a a e and ble	

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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CO A. BUILDING B. WING	00	сомр 02/21	SURVEY LETED /2013
	PROVIDER OR SUPPLIEI		2860 CH	DDRESS, CITY, STATE, ZIP COE HURCHMAN AVE	DE	
	N LIVING CENTER-			APOLIS, IN 46203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
	Medicaid: 62 Other: 11 Total: 84					
		cies reflect state n accordance with 410				
	-	v completed on March ïmberly Perigo, RN.				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF 1	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE		
GOLDEN	I LIVING CENTER	-INDIANAPOLIS	INDIA	NAPOLIS, IN 46203		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	
000279 SS=E	PLANS A facility must u assessment to o the resident's co The facility must care plan for eac measurable obje meet a resident' mental and psyc identified in the The care plan m that are to be fu the resident's hi mental, and psy required under § that would other §483.25 but are resident's exerc including the rig §483.10(b)(4). Based on inte review, the fac care plans, wh non-pharmaco and methods effectiveness, residents rece medications (face and #127) and (Resident #94) who met the o	APREHENSIVE CARE se the results of the develop, review and revise omprehensive plan of care. t develop a comprehensive ch resident that includes ectives and timetables to 's medical, nursing, and chosocial needs that are comprehensive assessment. thust describe the services rnished to attain or maintain ghest practicable physical, chosocial well-being as §483.25; and any services wise be required under not provided due to the ise of rights under §483.10, ht to refuse treatment under erview and record cility failed to ensure nich included offering pological interventions	F000279	F279 E I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R122 care plan was implemented R135 was discharged to hom R127 care plan was implemented. R94 care plan for pain was implemented.		

EPARTMEN	T OF HEALTH AND HU	JMAN SERVICES				FORM APPROVED
	R MEDICARE & MEDI					OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155138	B. WIN			02/21/2013
NAME OF 1	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP CODE	
				2860 C	CHURCHMAN AVE	
GOLDEN	N LIVING CENTER	-INDIANAPOLIS		INDIAN	NAPOLIS, IN 46203	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG		52
	Findings inclu	de:			II. Other residents having the	
					potential to be affected by t	
	1. The record	of Resident #122 was			same deficient practice will	
	reviewed on 2	/15/13 at 11:00 a.m.			identified and the corrective actions taken are as follows	
					actions taken are as follows	5:
	Diagnoses for	Resident #122			Any resident that had an or	der
	included, but v	were not limited to,			for anti-anxiety medication	
	closed femur f	fracture, adjustment			their care plan reviewed and	
		pecified psychosis,			updated as needed to ensur	re
		ind anxiety disorder.			there were interventions of	
					non-pharmacological	
	Resident #122	2 was admitted to the			interventions, care plan for	
		13/12. An admission			anxiety if on anti-anxiety medications.	
	Minimum Data					
		. ,			Residents on pain medicati	on
		ndicated his cognition			and/or anti anxiety were	
	was moderate	ely impaired.			reviewed to ensure that the	y l
					had a care plan related to pa	ain.
		order, dated 12/23/12,				
		ident #122 could				
		(an anti-anxiety			III. The measures put into	
	medication) 0.	.25 milligrams (mg.)			place and the systemic	at
	three times a	day as needed for			changes made to ensure the this deficient practice does	
	anxiety.				recur are as follows:	
	A Medication	Administration Record			New orders will be reviewed	k
	for Resident #	122 for January 2013,			during morning clinical	
	indicated he re	eceived Xanax on 1/4 at			meeting to ensure that	
	7:49 a.m., 1/7	at 7:59 a.m., 1/8 at			appropriate care plan has b	een
	6:52 a.m., 1/9	at 5:04 p.m., and 1/10			implemented.	
		The administration			DNS/Designee will audit nev	
		ed the medications were			orders and care plans 5 x a	
		ses' notes for January 4,			week for 8 weeks, then 3 tin	
		), 2013, did not indicate			a week for 8 weeks, and the	
					weekly for 8 weeks to ensur	
		nxiety symptoms or			that new medications are ca	
	non-pharmaco	ological interventions				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T1O311

311 Facility

Facility ID: 000063

If continuation sheet

Page 4 of 37

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE were attempted prior to the planned. administration of the Xanax. IV. These corrective actions A care plan for anxiety was not found will be monitored and a quality in Resident #122's record. assurance program implemented to ensure the deficient practice will not recur On 2/18/13 at 10:30 a.m., the Director per the following: of Nursing indicated an anxiety care plan for Resident #122 had not been created. **DNS/Designee will report** findings of audits to monthly 2. The record of Resident #135 was QA meetings for 6 months, any reviewed on 2/18/13 at 11:25 a.m. patterns or trends will have an action plan written and interventions implemented. Diagnoses for Resident #135 included, but were not limited to, seizures, drug dependence, post traumatic stress disorder, and ruptured aortic aneurysm. Resident #135 was admitted to the facility on 2/11/13. An admission MDS assessment, dated 2/16/13, indicated Resident #135 was independent in cognitive skills for daily decision making. A physician's order dated 2/11/13 indicated Resident #135 could receive Lorazepam, (an anti-anxiety medication) 2 mg., 4 times per day, as needed, for anxiety. A Medication Administration Record FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T10311 Facility ID: 000063 If continuation sheet Page 5 of 37

PRINTED:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE for Resident #135 for February 2013, indicated he received Lorazepam on 2/11 at 7:43 p.m., 2/12 at 9:28 a.m., 2/14 at 7:29 p.m., 2/15 at 3:40 p.m., 2/16 at 8:52 a.m., and 2/18 at 9:08 a.m. The administration record indicated the medications were effective. Nurses notes for February 11, 12, 14, 15, 16, and 18, 2013, did not indicate any non pharmacological interventions were attempted prior to the administration of the Lorazepam. A care plan for anxiety was not found in Resident #135's record. On 2/18 13 at 3:00 p.m., the DON indicated an anxiety care plan had not been created for Resident #122. 3. The record of Resident #127 was reviewed on 2/18/13 at 2:10 p.m. Diagnoses for Resident #127 included, but were not limited to, secondary Parkinsonism and depressive disorder. Resident #122 was admitted to the facility on 12/13/13. An admission MDS assessment, dated 12/20/12, indicated Resident #127 was independent in cognitive skills for daily decision making.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T1O311

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If continuation sheet Pa

Page 6 of 37

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS, IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE A physician's order, dated 1/26/13, indicated Resident #127 could receive Xanax, (an anti-anxiety medication) 0.25 mg., 2 times per day, as needed, for anxiety. Another physician's order, dated 1/29/13, indicated she was to receive a scheduled dose of Xanax, 0.25 mg., twice a day. Another physician's order, dated 2/5/13, indicated she was to receive Xanax, 0.25 mg., at bedtime every night. A care plan for anxiety was not found in Resident #127's record. On 2/18/13 at 3:50 p.m., the DON indicated an anxiety care plan had not been created for Resident #127 4. The record of Resident #94 was reviewed on 2/18/13 at 4:00 p.m. Diagnoses for Resident #94 included, but were not limited to, spinal cord injury, gastritis, depressive disorder, and pressure ulcer. Resident #94 was admitted to the facility on 4/12/12. A quarterly MDS assessment, dated 1/23/13, indicated Resident #94 was independent in cognitive skills for Facility ID: 000063

If continuation sheet

Page 7 of 37

PRINTED:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE GOLDEN LIVING CENTER-INDIANAPOLIS INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE daily decision making. It indicated the resident reported his pain as frequent and at a level of 4 (on a scale of 1 -10) A physician's order, dated 4/12/12, indicated Resident #94 could receive Norco, (a narcotic pain medication) 10-325 mg., 1 tablet, every 6 hours, as needed, for severe pain. A Medication Administration Record for January, 2013, indicated Resident #94 received Norco on 1/4 at 11:43 p.m., 1/10 at 3:24 p.m., 1/14 at 6:02 p.m., 1/15 at 6:36 p.m., 1/16 at 11:39 p.m., and 1/18 at 12:48 a.m. A care plan for pain was not found in the resident's record. On 2/19/13 at 11:00 a.m., the DON indicated a care plan for pain had not been created for Resident #94. 3.1-35(a)

Facility ID: 000063

063 If continu

If continuation sheet Page

Page 8 of 37

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION 00		(X3) DATE SURVEY COMPLETED	
	c. condenon	155138	A. BUILDING B. WING			21/2013	
NAME OF P	ROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP	CODE		
				HURCHMAN AVE			
GOLDEN	LIVING CENTER			IAPOLIS, IN 46203			
		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	-	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIC DATE	
IAU	REGULATORI U	KESCIDENTIFTING INFORMATION)				DAIL	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED	
		155138	A. BUILDING		02/21/2013	
			B. WING			
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	E	
GOLDEN	LIVING CENTER	INDIANAPOLIS	INDIAN	NAPOLIS, IN 46203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION (X	5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE	LD BE COMPLE	ETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DAT	Έ
000282	483.20(k)(3)(ii)					
SS=D		QUALIFIED PERSONS/PER				
		wided or arranged by the				
		provided by qualified dance with each resident's				
	written plan of ca					
		ecord review and	F000282	F282 D I. The corrective	<b>0</b> 3/15/	/2012
		facility failed to ensure	1 000202	actions accomplished for	-	201.
		-		residents found to have		
		were followed for 5 of		affected by the deficient		
		ho met the criteria for		practice are as follows:		
		inistering as needed		Residents listed in 2567	had	
	pain medicatio	on in a sample of 37.		charts reviewed.R135 wa	as	
	(Residents #6	8, #116, #122, #127		discharged home.R30 ha	ad lab	
	and #135)			drawn on 2/15/13. II. C	Other	
	-			residents having the pot	tential	
	2. Based on c	bservation, interview		to be affected by the sar		
		view, the facility failed to		deficient practice will be		
		tory services as		identified and the correct		
		-		actions taken are as follo	ows:	
	• •	physician for 1 of 10		Licensed nurses were		
		met the criteria for		educated on March 13, 2		
		ratory blood tests being		regarding documentatio		
	done to asses	s the effects of		pain, including but not li to location of pain, pain		
	medication in	a sample of 37.		on scale of 1-10 and follo	-	
	(Resident #30	)		assessment after pain		
				medication has been		
				administered. Licensed	nurses	
	Findings inclue	de.		were educated on March		
	. mango molu			2013 regarding monitori		
	1 A Thorson	ord of Resident #68 was		ensuring labs that are or	-	
				are drawn. Charts were		
	reviewed on 2	/18/13 at 8:40 a.m.		reviewed to ensure that	all	
				ordered labs had been d	Irawn.	
	Diagnoses for	Resident #68 included,		III. The measures put in	to	
	but were not li	mited to, fracture of the		place and the systemic		
	radius (arm bo	one), arthritis, and spinal		changes made to ensure		
	stenosis.			this deficient practice do		
				recur are as follows: Li	censed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

O311 Facil

If continuation sheet Page

Page 10 of 37

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S COMPLI <b>02/21/</b> 2	ETED
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE		
GOLDEI	N LIVING CENTER	-INDIANAPOLIS	INDIAN	NAPOLIS, IN 46203		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident #68 facility on 1/16 An admission (MDS) assess indicated Res independent w making, and h which limited was rated at " A care plan for 1/22/13, indica management to: Fracture to chronic back p stenosis." Goa will achieve ac goalWill ma comfort as ev [signs and syn pain or distress satisfaction w Interventions characteristics of pain,Eval patient's pain monitoring too effectiveness A physician's indicated Res Hydrocodone	was admitted to the 5/13. Minimum Data Set sment, dated 1/23/13, ident #68 was with daily decision had "frequent" pain her activities. The pain 6", on a scale of 1 - 10. r Resident #68, dated ated a problem of "Pain and monitoring related or right wrist, arthritis, painand spinal als included "Patient cceptable pain level intain adequate level of idenced by no s/sx mptoms] of unrelieved as, or verbalizing ith level of comfort" included "Evaluate and frequency/pattern uate what makes the worseUtilize pain		nurses were educated on March 13, 2013 regarding documentation of pain, including but not limited to location of pain, pain rating scale of 1-10 and follow up assessment after pain medication has been administered and on ensurin labs that are ordered are drawn. DNS/Designee will audit nurse's notes daily to ensure that any prn pain medication given will have documentation that includes location of pain, pain rating scale of 1-10 and follow up assessment after pain medication has been administered. DNS/Designee will audit new orders during morning clinical meetings utilzing the lab monitoring to to ensure that all ordered lat have been drawn. The audit will be conducted 5 times a week for 8 weeks, then 3 tim a week for 8 weeks and then weekly as ongoing process. IV. These corrective actions will be monitored and a qual assurance program implemented to ensure the deficient practice will not rec per the following: DNS/Designee will report findings of audits to monthly QA meetings for 6 months, a patterns or trends will have action plan written and	ig ; on ; on ; ee ; ool ; s ; es ; ity ; ur ; ur	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T1O311

Facility ID: 000063

If continuation sheet Page 11 of 37

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	Ì.	JILDING	ONSTRUCTION 00	COM	te survey Mpleted 21/2013
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP	CODE	
GOLDE	N LIVING CENTER	-INDIANAPOLIS			HURCHMAN AVE IAPOLIS, IN 46203		
(X4) ID	-	STATEMENT OF DEFICIENCIES		ID	1		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC
	milligrams, (m hours, as nee	ng.) 1 tablet, every 6 ded, for pain.			interventions implem	nented.	
	for January ar indicated Res Hydrocodone 1/25 at 5:55 a 1/30 at 3:05 a a.m. No nurs found to indica location of the monitoring too						
	indicated Res Tramadol (a r	order, dated 1/16/13, ident #68 could receive non-narcotic pain relief 0 mg. 1 tablet every 5 ded.					
	for January ar indicated Res Tramadol on nursing docur indicate reaso characteristics	dministration Records nd February, 2013, ident #68 received 1/17, 1/20, and 1/24. No nentation was found to on for giving, s or location of pain, or monitoring tool.					
	reviewed on 2	of Resident #116 was 2/19/13 at 2:00 p.m.					
	-	<sup>·</sup> Resident #116 were not limited to,					

## **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE chronic pain syndrome, depressive disorder, and osteoarthrosis. Resident #116 was admitted to the facility on 11/26/12. An admission MDS, dated 12/3/12, indicated Resident #116 was independent in her daily decision making, and she rated her pain as " frequent" at a level of "8," on a scale of 1 - 10. A care plan for Resident #116, dated 12/5/12, indicated a focus of "Needs pain management and monitoring related to: Chronic pain syndrome ... " Interventions included "...Evaluate and Establish level of pain on numeric scale/evaluation tool...Evaluate characteristics and frequency/pattern of pain...Utilize pain monitoring tool to evaluate effectiveness of interventions..." A physician's order dated 11/26/12, indicated Resident #116 could receive Morphine Sulfate, 15 mg., 1 tablet ,every 4 hours, as needed. Medication Administration Records for January and February, 2013, indicated Resident #116 received Morphine 15 mgs on 1/2/13 at 5:18 a.m. and 4:09 p.m., and 2/19/13 at Facility ID: 000063

If continuation sheet

Page 13 of 37

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03/25/2013

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 7:11 p.m. No nursing documentation was found to indicate the location of her pain, or that it was evaluated on a numeric scale at the time of these morphine administrations. There was no documentation to indicate a pain monitoring tool was used. C. The record of Resident #122 was reviewed on 2/15/13 at 11:00 a.m. Diagnoses for Resident #122 included, but were not limited to, femur fracture, chronic pain, and infection of the bone in lower leg. Resident #122 was admitted to the facility on 11/13/12. An Admission MDS assessment. dated 11/20/12, indicated Resident #122 was moderately cognitively impaired, and rated his pain as "frequent" at a level "8," on a scale of 1 - 10. A care plan for Resident #122, dated 11/23/11, indicated a problem of "Needs Pain management and monitoring related to: Wound, Surgical Procedure and dx [diagnosis] of chronic pain. Interventions included "... Evaluate and Establish level of pain on numeric scale/evaluation tool..." Facility ID: 000063

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

If continuation sheet

Page 14 of 37

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 02/21/2013 155138 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE A physician's order, dated 1/14/13, indicated Resident #122 could receive Oxycodone-Acetaminophen, (a narcotic pain medication) 5-325 mg., 1 or 2 tablets, every 4 hours, as needed. A Medication Administration Record for February, 2013, indicated Resident #122 received 2 tablets of Oxycodone-Acetaminophen 5-325 mg. on February 2, at 2:18 a.m., 2/4 at 12:34 a.m., and 4:09 p.m., 2/5 at 2:06 a.m., and 9:28 a.m., 2/6 at 1:07 a.m., 2/7 at 2:50 a.m., 2/9 at 1:56 a.m., 2/11 at 9:29 a.m., 2/12 at 8:42 a.m., 2/13 at 8:12 a.m., 2/14 at 8:28 a.m., 2/15 at 11:54 a.m., and 2/16 at 9:11 a.m., 2013. No nursing documentation was found to indicate the location of his pain, or that it was evaluated on a numeric scale at the time of these Oxycodone-Acetaminophen medication administrations. There was no documentation to indicate a pain monitoring tool was used. D. The record of Resident #127 was reviewed on 2/18/13 at 2:10 p.m. Diagnoses for Resident #127 included, but were not limited to, secondary Parkinson's disease and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

Facility ID: 000063

If continuation sheet

Page 15 of 37

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 02/21/2013 155138 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE arthropathy. Resident #127 was admitted to the facility on 12/13/12. An admission MDS assessment, dated 11/2012, indicated Resident #127 was independent with daily decision making, and had "frequent" pain rated at a level "6" on a scale of 1 - 10. A care plan for Resident #127, dated 1/20 13, indicated a problem of "Pain management and monitoring related to Osteoarthritis..." Interventions included "Evaluate and Establish level of pain on numeric scale/evaluation tool..." A physician's order, dated 12/13/12, indicated Resident #127 could receive Norco, 7.5-325 mg, (a narcotic pain medication) 1 tablet, every 4 hours, as needed, for pain. A Medication Administration Record for January, 2013, indicated Resident #127 received Norco on January 4 at 7:48 a.m., 1/5 at 11:54 p.m., 1/12 at 7:57 a.m., 1/15 at 4:23 p.m., and 1/21 at 2:47 a.m., 2013. No nursing documentation was found to indicate the location of her pain, or that it was evaluated on a numeric scale at the Page 16 of 37

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

Facility ID: 000063

If continuation sheet

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE time of these Norco medication administrations. There was no documentation to indicate a pain monitoring tool was used. E. The record of Resident #135 was reviewed on 2/18/13 at 11:25 a.m. Diagnoses for Resident #135 included, but were not limited to drug dependence and abscess of the mediastinum. Resident #135 was admitted to the facility on 2/11/13. An admission MDS assessment, dated 2/16/13, indicated he was independent with his daily decision making. A care plan for Resident #135, dated 2/12/13, indicated a problem of "Needs Pain management and monitoring related to: Wound, Surgical Procedure..." Interventions included "... Evaluate and Establish level of pain on numeric scale/evaluation tool..." A physician's order, dated 2/11/13, indicated Resident #135 could receive Oxycodone-Acetaminophen, 10-325 mg., 2 tablets, every 4 hours, as needed, for pain. A Medication Administration Record FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T10311 Facility ID: 000063 If continuation sheet Page 17 of 37

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 02/21/2013 155138 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE for February, 2013 indicated Resident #135 received Oxycodone-Acetaminophen 10-325 mg on 2/12 at 4:24 a.m., 8:33 a.m., 12:50 p.m. and 4:04 p.m., 2/13 at 2:24 p.m., 2/15 at 3:40 p.m., and 2/18 at 9:06 a.m. There was no documentation in the resident's record to indicate the location of his pain, or that it was evaluated on a numeric scale, prior to the administration of this pain medication. A facility policy, titled "Administration Procedures For All Medications," dated November, 2011, received from the Director of Nursing (DON) on 2/18/13 at 9:00 a.m. indicated "...When administering an 'as needed' (PRN) medication, document reason for giving, observe for medication/reactions and record [on the PRN effectiveness sheet/nurses's notes]." During an interview with the DON on 2/18/13 9:00 a.m., she indicated nurses should be documenting the intensity and location of the pain. She indicated at this time the facility was no longer using a, "pain monitoring tool." Facility ID: 000063 If continuation sheet

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

Page 18 of 37

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) E	OATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Ĩ,		00	C	OMPLETED
		155138		UILDING		0:	2/21/2013
			В. W	/ING	ADDREGG GITTY OT ATE T	_	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZI	I CODE	
	N LIVING CENTER						
GOLDEI	N LIVING CENTER	-INDIANAPOLIS		INDIAN	IAPOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY	)	DATE
		record for Resident #30 on 2/15/13 at 10:00					
	the facility on						
	-	Resident #30 included, mited to, diabetes					
	recapitulated Resident #30 (Hemoglobin / blood/plasma test done even last HgbAIC te	e January physician's orders indicated was to have a HgbAIC A1C, a test to measure sugar levels) laboratory ry three months. The est was completed on oximately 4 months					
	(Director of No 12:30 p.m., fu requested for	rview with the DON ursing) on 2/15/13 at rther information was the HbgAIC test that d to be done in January,					
	2/15/13 at 3:0 there was no in January, as	rview with the DON on 0 p.m., she indicated HgbAIC test completed ordered. At this time ered a STAT (to be					

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CC A. BUILDING B. WING	00	- 02/2	te survey pleted 21/2013
	PROVIDER OR SUPPLIE		2860 C	ADDRESS, CITY, STATE, ZIP CO HURCHMAN AVE IAPOLIS, IN 46203	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	done immedia Resident #30. A facility polic titled "Lab Pro Guideline," in	ately) HgbAIC test for y, dated January, 2011, ocessing/Tracking idicated "labs are d drawn as per				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155138	B. WING		02/21/2013
		D	STREET	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	ROVIDER OR SUPPLIE	ĸ	2860 C	HURCHMAN AVE	
GOLDEN	LIVING CENTER	-INDIANAPOLIS	INDIAN	IAPOLIS, IN 46203	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
000329	483.25(l)				
SS=D		N IS FREE FROM			
	UNNECESSAR				
		drug regimen must be free			
		ry drugs. An unnecessary when used in excessive			
		duplicate therapy); or for			
	· ·	on; or without adequate			
		ithout adequate indications			
	-	the presence of adverse			
	consequences w	hich indicate the dose			
	should be reduce	ed or discontinued; or any			
	combinations of	the reasons above.			
	Based on a com	prehensive assessment of a			
	resident, the fac	ility must ensure that			
	residents who ha	ave not used antipsychotic			
	• •	en these drugs unless			
		ug therapy is necessary to			
		ondition as diagnosed and			
		he clinical record; and se antipsychotic drugs			
		dose reductions, and			
	U	rentions, unless clinically			
		in an effort to discontinue			
	these drugs.				
			F000329	F329D	03/15/2013
	1. Based on re	ecord review and			
		facility failed to ensure		I. The corrective actions	
		was assessed for		accomplished for those	
	•			residents found to have bee	n
		ntensity and their		affected by the deficient	
	•	ssessed for cause and		practice are as follows:	
		n-pharmacological			
		vere offered to the		R135 was discharged home	.
	residents prior	to the administration of		R122 had pain medication an	ומ
	as needed pai	n and anti-anxiety		physician wants the prn	
	medications.	This affected 4 of 10		medication. Anti anxiety prn medication was discontinue	
	residents who	met the criteria for		R127 had prn Anti anxiety	u.
		ecessary medication		medication reviewed with th	e
			1		~ I

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS, IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE resident's physician and prn administration in a sample of 37. medication was changed to (Residents #94, #122, 127, 135) routine. R94 had prn pain medication 2. Based on observation, interview reviewed with the resident's and record review, the facility failed to physician and prn medication provide reasoning for an increase in was not changed per MD but an antipsychotic medication for 1 of the nursing staff was educated on assessing and documenting 10 residents reviewed for on pain. unnecessary medications in a sample R30 was seen by her of 10 residents. (Resident # Psychiatrist on 2-18-13 and #30) documented "tolerating recent increase in Risperdal with improvement in psychosis (delusions and hallucinations". Findings include: 1. A. The record of Resident #94 was II. Other residents having the reviewed on 2/18/13 at 4:00 p.m. potential to be affected by the same deficient practice will be Diagnoses for Resident #94 included, identified and the corrective but were not limited to, spinal cord actions taken are as follows: injury, gastritis, depressive disorder, Education was held on March and pressure ulcer. 13, 2013 regarding documentation of pain, Resident #94 was admitted to the including but not limited to facility on 4/12/12. location of pain, pain rating on scale of 1-10 and follow up assessment after pain A quarterly MDS assessment, dated medication has been 1/23/13, indicated Resident #94 was administered. independent in cognitive skills for daily decision making. It indicated the resident reported his pain as frequent III. The measures put into and at a level of 4 (on a scale of 1 place and the systemic changes made to ensure that 10). this deficient practice does not recur are as follows: A physician's order, dated 4/12/12,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T1O311

311 Facility

Facility ID: 000063

If continuation sheet

Page 22 of 37

PRINTED:

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	X3) DATE SURVEY COMPLETED 02/21/2013	
	PROVIDER OR SUPPLIE		28	860 C	ADDRESS, CITY, STATE, ZIP CODE HURCHMAN AVE IAPOLIS, IN 46203		
	-				IAPOLIS, IN 40203		(375)
X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	IE PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	indicated Res	ident #94 could receive					
		otic pain medication)			Education was held on Marc	h	
	•	nilligrams) 1 tablet every			13, 2013 regarding		
	- ·	eded for severe pain.			documentation of pain,		
					including but not limited to		
	A Medication	Administration Record			location of pain, pain rating scale of 1-10 and follow up	on	
		013, indicated Resident			assessment after pain		
		Norco on 1/4 at 11:43			medication has been		
		3:24 p.m., 1/14 at 6:02			administered.		
		5:36 p.m., 1/1 at 11:39					
		at 12:48 a.m. The			IDT will have a Behavior		
		indicate the location or			meeting March 18, 2013 to	otu i	
		intensity of the pain, or			review the residents on anxi medications and possible do	-	
		pharmacological			reduction. Any drug reduction		
		were offered prior to			or increase will include		
		strations of Norco.			appropriate reason.		
	1 B The rec	ord of Resident #122			Behavior Meetings will be he		
		on 2/15/13 at 11:00			monthly which will include b not limited to Nursing	ut	
	a.m.	on 2/10/10 at 11:00			Management, Social Service	s.	
	a.m.				facility medical director,	-,	
	Diagnoses for	Resident #122			psychiatrist and psychologis	st.	
	-	were not limited to,					
		e, chronic pain, and			DNS/Designee will audit new		
		e bone in lower leg.			orders for anxiety medicatio and any documentation of p		
					pain administrated 5 x a wee		
	Resident #123	2 was admitted to the			for 8 weeks, then 3 times a		
	facility on 11/2				week for 8 weeks, and the		
					weekly for 8 weeks to ensure		
	An Admission	MDS assessment,			that new medications are cal	re	
		2, indicated Resident			planned.		
		derately cognitively					
		rated his pain as			IV. These corrective actions		
		evel 8, on a scale of 1 -			will be monitored and a qual	ity	
	10.				assurance program		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000063

If continuation sheet Page 23 of 37

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	r í	TE SURVEY 1PLETED
		155138	A. BI B. W	JILDING ING		- 02/2	21/2013
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	CODE	
GOLDE	N LIVING CENTER	-INDIANAPOLIS			CHURCHMAN AVE NAPOLIS, IN 46203		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	APPROPRIATE	COMPLETIC DATE
		· · · · ·			implemented to ensu		
	•	r Resident #122, dated			deficient practice will per the following:	not recur	
		cated a problem of			per the following.		
		nanagement and ated to: Wound,			DNS/Designee will re		
		edure and dx [diagnosis]			findings of audits to r QA meetings for 6 mo	-	
	-	n." Interventions			patterns or trends wil		
		aluate and Establish			action plan written an		
	level of pain o scale/evaluati				interventions implem	ented.	
	indicated Res receive Oxyco (a narcotic pa	order, dated 1/14/13, ident #122 could odone-Acetaminophen in medication) 5-325 lets every 4 hours as					
	for February, 2 Resident #122 Oxycodone-A mg. on Februa at 12:34 a.m. 12:06 a.m. an a.m., 2/7 at 2: a.m., 2/11 at 9 a.m., 2/13 at a.m., 2/15 at 9:11 a.m., 207	Administration Record 2013, indicated 2 received 2 tablets of cetaminophen 5-325 ary 2 at 2:18 a.m., 2/4 and 4:09 p.m., 2/5 at d 9:28 a.m., 2/6 at 1:07 50 a.m., 2/9 at 1:56 9:29 a.m., 2/12 at 8:42 8:12 a.m., 2/14 at 8:28 11:54 a.m., and 2/16 at 13.					
	location or nu Resident #122	merical intensity of 2's pain or if alternative, blogical interventions					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE were offered prior to these administrations of Oxycodone-Acetaminophen. A physician's order, dated 12/23/12, indicated Resident #122 could receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg.) three times a day as needed for anxiety. A Medication Administration Record for Resident #122 for January, 2013, indicated he received Xanax on 1/4 at 7:49 a.m., 1/7 at 7:59 a.m., 1/8 at 6:52 a.m., 1/9 at 5:04 p.m. and 1/10 at 8:19 a.m. The administration record indicated the medications were effective. Nurses' notes for January 4, 7, 8, 9 and 10 did not indicate specify anxiety symptoms or whether non-pharmacological interventions were attempted prior to the administration of the Xanax. 1.C. The record of Resident #127 was reviewed on 2/18/13 at 2:10 p.m. Diagnoses for Resident #127 included, but were not limited to, secondary Parkinson's disease and arthropathy. Resident #127 was admitted to the facility on 12/13/12. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T10311 Facility ID: 000063 If continuation sheet Page 25 of 37

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 02/21/2013 155138 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE An admission MDS assessment. dated 11/2012, indicated Resident #127 was independent with daily decision making and had frequent pain rated at a level 6 on a scale of 1 - 10. A care plan for Resident #127, dated 1/20 13, indicated a problem of "Pain management and monitoring related to Osteoarthritis..." Interventions included "Evaluate and Establish level of pain on numeric scale/evaluation tool..." A physician's order, dated 12/13/12, indicated Resident #127 could receive Norco 7.5-325 mg, (a narcotic pain medication) 1 tablet, every 4 hours as needed for pain. A physician's order, dated 1/26/13 indicated Resident #127 could receive Xanax, (an anti-anxiety medication) 0.25 mg 2 times per day as needed for anxiety. A Medication Administration Record for January, 2013, indicated Resident #127 received Narco on January 4 at 7:48 a.m., on 1/5 at 11:54 p.m., on 1/12 at 7:57 a.m., on 1/15 at 4:23 p.m., and 1/21 at 2:47 a.m., 2013. Nurse's notes did not indicate the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

311 Facility ID:

Facility ID: 000063

If continuation sheet Pa

Page 26 of 37

PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE location or numerical intensity of the resident's pain or whether alternative non-pharmacological interventions were offered to the resident prior to these administrations of Narco. A physician's order, dated 1/26/13 indicated Resident #127 could receive Xanax, (an anti-anxiety medication) 0.25 mg 2 times per day as needed for anxiety. A Medication Administration Record for January, 2013, indicated Resident #127 received Xanax on 1/28 at 8:20 a.m. Nurses' notes for January 28, 2013, did not specify anxiety symptoms or whether non-pharmacological interventions were attempted prior to the administration of the Xanax. 1.D. The record of Resident #135 was reviewed on 2/18/13 at 11:25 a.m. Diagnoses for Resident #135 included, but were not limited to, drug dependence and abscess of the mediastinum (the area in the chest between the lungs). Resident #135 was admitted to the facility on 2/11/13. An admission MDS assessment dated 2/16/13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T10311

Facility ID: 000063

If continuation sheet

Page 27 of 37

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE GOLDEN LIVING CENTER-INDIANAPOLIS INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE indicated he was independent with his daily decision making. A care plan for Resident #135, dated 2/12/13, indicated a problem of "Needs Pain management and monitoring related to: Wound, Surgical Procedure..." Interventions included "... Evaluate and Establish level of pain on numeric scale/evaluation tool..." A physician's order, dated 2/11/13, indicated Resident #135 could receive Oxycodone-Acetaminophen 10-325 mg. 2 tablets every 4 hours as needed for pain. A Medication Administration Record for February, 2013 indicated Resident #135 received Oxycodone-Acetaminophen 10-325 mg on 2/12 at 4:24 a.m., 8:33 a.m., 12:50 p.m., and 4:04 p.m., 2/13 at 2:24 p.m., 2/15 at 3:40 p.m., and 2/18 at 9:06 a.m. There was no documentation in the resident's record to indicate the location or numeric intensity prior to the administration of this pain medication. A physician's order dated 2/11/13 indicated Resident #135 could receive Lorazepam (an anti-anxiety medication) 2 mg. 4 times per day as

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Event ID: T1O311

Facility ID: 000063

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If continuation sheet P

Page 28 of 37

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3)	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155138		BUILDING	00		COMPLETED 02/21/2013
			D. W		ADDRESS, CITY, STATE, Z		
NAME OF	PROVIDER OR SUPPLIE	ER			HURCHMAN AVE	II CODE	
GOLDE	N LIVING CENTER	-INDIANAPOLIS			APOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	<u> </u>	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION	ON SHOULD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE
	needed for an	· · · · · · · · · · · · · · · · · · ·					
		Noty.					
	A Medication	Administration Record					
		135 for February, 2013,					
		eceived Lorazepam on					
		.m., 2/12 at 9:28 a.m.,					
		.m., 2/15 at 3:40 p.m.,					
		.m., and 2/18 at 9:08					
		ninistration record					
		medications were					
		ses notes for February					
		, 16, and 18 did not					
		y symptoms or whether					
		on-pharmacological					
		were offered prior to					
	these adminis	trations of Lorazepam.					
	• •	y, titled "Administration					
	Procedures F	or All Medications,"					
	dated Novem	ber, 2011, received from					
	the Director o	f Nursing (DON) on					
	2/18/13 at 9:0	0 a.m. indicated					
	"When adm	inistering an 'as needed'					
	(PRN) medica	ation, document reason					
	for giving, obs	serve for					
	medication/re	actions and record [on					
	the PRN effect	tiveness sheet/nurses's					
	notes]."						
	-	erview with the DON on					
		a.m., she indicated					
		be documenting the					
	-	ocation of the pain on a					
		scale and offering					
	non-pharmac	ological interventions to					

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155138	(X2) MULTIF A. BUILDING B. WING	- -	00	- 02/	te survey Mpleted 21/2013
	PROVIDER OR SUPPLIEI		28	60 CHUF	RESS, CITY, STATE, ZIP CO RCHMAN AVE	DE	
GOLDEI	N LIVING CENTER-	INDIANAPOLIS	IN		OLIS, IN 46203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREF TA	C	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
		g anxiety prior to the of pain and anxiety					
	was reviewed a.m. Resident the facility on 6 Diagnoses for	Resident #30 included					
	psychosis (a p triggered by a	nited to, reactive sychotic episode traumatic event), ersonality disorder.					
	Physician Servindicated Resid Risperdal 0.5 r It also stated " not feel Risper	rmacist Letter to vices" on 1/11/13, dent #30 was taking ng BID (twice daily). Nursing states they do dal is helping with the ociated. She has had					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	A. BUIL B. WINC		00	COMPI 02/21	
	PROVIDER OR SUPPLIEI N LIVING CENTER-			2860 CH	DDRESS, CITY, STATE, ZIP COE HURCHMAN AVE APOLIS, IN 46203	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
	to try a reduction physician that recommendation increased to 1 and no other control A "Physician's found dated 1// "increase Risp (by mouth, twice A "Nursing Hot Subsequent Via Resident #30 H (antibiotic) for infection)" and "paranoia and During an inter (Director of Nut 12:30 p.m., fur requested in re- physician felt to antipsychotic re- necessary. No further infor by the facility in physicians decor- Resident #30's medication. A facility policy	on responded, "was mg BID on 1/15/13," omments. Orders" note was 15/13 and stated erdal to 1 mg PO BID ce daily) for psychosis." me Psychiatric sit Form" indicated had been on an "ABT a UTI (urinary tract had an Episode of crying on 1/17/13." view with the DON rsing) on 2/15/13 at ther information was egards to why the ne increase in the nedication was					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3) D	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00		OMPLETED
		155138		LDING		— 02	2/21/2013
			B. WIN		NUMBER CITY OTATE 710		
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP (	LODE	
	N LIVING CENTER				URCHMAN AVE POLIS, IN 46203		
					r Oli3, in 40203		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Drugs" indicated,					
		on is needed in the					
		cord why additional					
		n will cause impairment,					
		ability, or exacerbate the					
	underlying ps	chiatric disorder."					
	3.1-48(a)(3)						
	3.1-48(a)(4)						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 02/21/2013 155138 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE F000371 483.35(i) SS=E 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 F000371 03/15/2013 Based on observation and interview, F371 E the facility failed to maintain sanitary I. The corrective actions conditions in the kitchen. This had accomplished for those the potential to affect residents (87) residents found to have been who received meals from the facility's affected by the deficient kitchen. practice are as follows: Findings Include: The outdated tomato soup and spaghetti sauce were discarded on 2/12/13 and not During an observation of the facility's used for meal preparation. kitchen on 2/12/13, at 10:45 a.m., expired food was noted in the The dietary manager was refrigerator. The expired food was as educated on hair restraints on follows... 2/12/13. She wore 2 hair nets & a head band during the survey. Tomato Soup, dated 1/29/13, use by 2/1/13 In-service was given to dietary Tomato Soup, dated 1/31/13, use by staff on facility policy on 2/7/13 labeling food items and Spaghetti Sauce, dated 2/6/13, use discarding outdated items by by 2/9/13 the Dietary Manager on 2/12/12. In-service was provided to During an observation of the food dietary staff on facility policy preparation for lunch time meal on on hair restraints by the Dietary 2/12/13 at 11:15 a.m., the Dietary Manager on 2/12/13. Manager was observed to have pieces of her hair hanging out from II. Other residents having the under the head covering she was potential to be affected by the

Facility ID: 000063

If continuation sheet

Page 33 of 37

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			te survey Ipleted 21/2013
	PROVIDER OR SUPPLIE		286	eet address, city, state, zip ( 0 CHURCHMAN AVE IANAPOLIS, IN 46203	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI2 TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE
	wearing. During an inte 11:00 a.m., th indicated she refrigerator fo and didn't not She also indic cook on this d	erview on 2/12/13 at e Dietary Manager had checked the r expired food previously e any expired foods. cated she was helping to lay because she had s who had called off of		<ul> <li>same deficient practividentified and the conditions taken are as a fixed actions taken are as a fixed provide the beginning of each Outdated food will be discarded.</li> <li>The dietary manager educated on hair rest 2/12/13. She will kee contained.</li> <li>III. The measures purplace and the system changes made to ensith this deficient practice recur are as follows:</li> <li>Food preparation and procedures will be midaily (at least 5 times for 4 weeks) by the D the RD during consult visits.</li> <li>IV. These corrective will be midaily consult visits.</li> <li>IV. These corrective will be midaily the following:</li> <li>The Dietary Manager any trends of deficient found to the QAPI Coon a monthly basis for months for recommendation and procedures will be and the system consult visits.</li> </ul>	rrective follows: onitored at h shift. was traints on p her hair t into hic sure that e does not d storage onitored s per week SM and/or ltation actions d a quality rre the I not recur will report ncies por 3	

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	MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION		MB NO. 0938-03 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			00		PLETED
		155138	A. BUII B. WIN			02/2	1/2013
			5. () 1 (		ADDRESS, CITY, STATE, ZIP COD	DE	
NAME OF PF	ROVIDER OR SUPPLI	ER		2860 CH	HURCHMAN AVE		
GOLDEN	LIVING CENTER	R-INDIANAPOLIS		INDIAN	APOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NOTRIATE	DATE
					and resolutions.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP, CODE		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE	
GOLDEN	N LIVING CENTER	-INDIANAPOLIS		NAPOLIS, IN 46203	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
009999	interview, the 1st step (Emp (Employees # annual (Emplo tests were cor employees hir	ord review and facility failed to ensure loyee #20), 2nd step 4, #48, and #62), and oyee #8) tuberculin skin mpleted for 5 of 13 red in 2010 or 2012. , #8, #20, #48, and #62) de:	F009999	<ul> <li>99999</li> <li>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</li> <li>First step, 2nd step and annut tuberculin skin tests will be completed for employees #4, #8, #20, #48 &amp; #62.</li> </ul>	Jal
	2/20/13 at 3:0 following findin Employee # 4 Title: Regi was documen tuberculin skir second step to found. Employee #8 Title: Regi evidence of a test was found Employee #20 Title: License was no docum	Date of hire 11/20/12 stered Nurse. There tation of first step n test. No evidence of a uberculin skin test was Date of hire 04/06/10 stered Nurse. No n annual tuberculin skin		<ul> <li>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</li> <li>An audit (using a payroll list) all employees will be conducted to determine what employees are in need of a timely tuberculin skin test.</li> <li>Employees having been four with an outdated tuberculin skin test.</li> <li>III. The measures put into place and the systemic changes made to ensure that this deficient practice does measure as follows:</li> </ul>	e be o of t nd

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T1O311

Facility ID: 000063

If continuation sheet

Page 36 of 37

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155138 02/21/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE **GOLDEN LIVING CENTER-INDIANAPOLIS** INDIANAPOLIS. IN 46203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG All new employees will receive Employee #48 Date of hire 11/27/12 TB testing upon hire per facility Title: Certified Nurse Aide. There policy. was documentation of first step tuberculin skin test. No evidence of a Annual TB testing will be second step tuberculin skin test was completed for all employee's found. per facility policy. The Director of Clinical Employee #62 Date of hire 12/24/12 Education (DCE) will oversee Title: Certified Nurse Aide. There the monitoring and was documentation of first step administration of TB test for all tuberculin skin test. No evidence of a employees. second step tuberculin skin test was found. IV. These corrective actions will be monitored and a quality The Executive Director was assurance program interviewed on 2/20/13 at 4:00 p.m., implemented to ensure the and indicated the documentation for deficient practice will not recur tuberculin skin test for employee files per the following: reviewed was lacking and not DCE/Designee will report performed. findings of the audit to monthly QAPI meetings for 6 months, 3.1-14(t)(1)any patterns or trends will have an action plan written and interventions implemented.

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Facility ID: 000063

0063 If con

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Page 37 of 37

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