

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2011
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NAME OF PROVIDER OR SUPPLIER  GREEN TREE AT POST ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN46219
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 19 and 20, 2011</p> <p>Facility number: 011799 Provider number: 011799 AIM number: N/A</p> <p>Survey Team: Diana Zgonc RN, TC Connie Landman, RN Christi Davidson, RN Courtney Hamilton, RN</p> <p>Census bed type: Residential: 27 Total: 27</p> <p>Census payor type: Other: 27 Total: 27</p> <p>Sample: 8</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/21/11 Cathy Emswiller RN</p>	R0000	<p>The following is the Plan of Correction for the (Green Tree) Samara in regards to the Statement Of Deficiencies for the annual survey completed December 20, 2012. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction nor fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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R0052	<p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>Based on record review and interview the facility failed to ensure residents who were cognitively impaired were treated with respect and dignity for 2 of 2 abuse investigation (Resident #10, Resident # 6, Resident Care Specialist [RCS] # 1 and RCS # 2).</p> <p>Findings include:</p> <p>1. The record for Resident # 10 was reviewed on 12/19/11 at 9:05 A.M.</p> <p>Diagnoses for Resident # 10 included but were not limited to advanced dementia with agitation and Anxiety.</p> <p>During review of the "Facility Incident Reporting Form" on 12/19/11 at 2:30 P.M., a CNA instructor reported to the Director of Nursing (DON) on 11/7/11 that RCS # 1 had indicated to the students, Resident # 10 had been known to spit. When the RCS told the students this information Resident # 10 began to spit. RCS # 1 removed a pair of the resident's underwear from his drawer and placed them on his head to prevent the</p>	R0052	<p>The Residents were assessed and care plans updated as appropriate. The Family, Physician, Hospice, appropriate agencies, and ISDH were notified. An investigation was performed. No other Residents were identified as being affected. The Associates involved in the deficient practice were terminated upon the completion of the investigation. A mandatory Resident's Rights in-service was conducted at the time of each incident with the (Green Tree) Samara Associates. An Educational Seminar, by Legacy Corporation, included subjects Resident Rights, Alzheimer and Related Diseases was conducted for all the (Green Tree) Samara Associates in December 2011. The educational program will continue for all new Associates with the first seminar January 31, 2012. The nursing Director and , or Designee will monitor three shifts, 1st shift, 2nd shift and 3rd shift, weekly for compliance to the Resident Rights. the monitoring results will be reviewed during the Director's Meeting weekly for the next 60 days.</p>	01/31/2012			

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	<p>spitting.</p> <p>2. The record for Resident # 6 was reviewed on 12/20/11 at 11:35 A.M.</p> <p>Diagnosis for Resident # 6 included but was not limited to dementia.</p> <p>During review of the "Facility Incident Reporting Form" on 12/19/11 at 2:30 P.M., the CNA instructor reported to the DON on 12/14/11, LPN # 7 stopped a student from feeding Resident # 6 and told the student to return the resident to her room if she refused to eat. The resident had requested a bowl of oatmeal but the LPN provided the resident with pudding instead. The CNA instructor refused to allow the student to return the resident to her room so LPN # 7 returned the resident to her room without assisting the resident to eat.</p> <p>The facility investigated the allegations and found them to be accurate and all 3 employees were fired, resident's were assessed and care plans updated as appropriate. The information was provided to the appropriate agencies: hospice, physician, family and state agencies.</p> <p>5-1.2(v)(2)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012

FORM APPROVED

OMB NO. 0938-0391

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R0121	<p>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure annual</p>	R0121	Dietary Aide #5 (Correction from #8 / #8 is a LPN) had a Tuberculin skin test December	01/31/2012			

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	<p>tuberculosis testing was conducted on an employee employed for over a year by the facility. This affected 1 of 7 employees (Dietary Aide #8).</p> <p>Findings include:</p> <p>During review of employee files on 12/20/2011 at 1:45 P.M., Dietary Aide #8's file indicated the most recent tuberculosis test was dated 9/25/2010.</p> <p>During an interview with the DON on 12/20/2011 at 2:10 P.M., she indicated Dietary Aide #8 had not had an annual tuberculosis screen. She indicated it was an oversight.</p> <p>A current facility policy provided by the RD on 12/20/2011 at 3:30 P.M., titled "TB Tests" dated 03/01/2011, indicated "...In accordance with state law, a TB [tuberculosis] test may be required prior to hire, with a second test seven days later, and then annually thereafter...".</p>		<p>20, 2011. An audit of all personnel files will be performed. If any other personnel is found to be in need of an annual Tuberculin testing it will be performed immediately. A monthly tickler file will be used and updated as new personnel are hired. The HR Director and Nursing Director will monitor monthly to ensure the deficient practice does not recur. The monitoring results will be presented monthly in the Director's Meeting.</p>				

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R0217	<p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure a service plan was developed for 1 resident and reviewed and updated for 1 resident reviewed for service plans in a sample of 8 (Resident #50 and Resident #17).</p> <p>Findings include:</p>	R0217	Resident #50 is deceased. The Licensed Nurse reviewed and up-dated Resident #17's service plan December 23, 2011. The Facility will not review the Discharged / deceased Residents files, ie, resident #50. The Resident's files will be audited by a Licensed Nurse for current and completed service plans. All services required for each individual will be addressed in the	01/31/2012			

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	<p>1. The record for Resident #50 was reviewed on 12/19/11 at 2:00 P.M.</p> <p>Diagnoses included, but were not limited to, unspecified psychosis, advanced dementia, hypothyroid, anorexic, chronic pain, and hypertension.</p> <p>Resident #50 was admitted to the facility on 8/31/11, and died on 11/5/11.</p> <p>The record lacked documentation of a Service Plan for this resident.</p> <p>During the daily conference with the Administrator and DON (Director of Nursing) on 12/19/11 at 4:30 P.M., a Service Plan for Resident #50 was requested.</p> <p>During an interview with the Administrator and DON on 12/20/11 at 2:00 P.M., the Administrator indicated Resident #50 did not have a Service Plan.</p> <p>2. Resident #17's record was reviewed on 12/19/2011 at 2:15 P.M., diagnoses included but were not limited to dementia, depression, hypertension, diabetes, and anxiety.</p> <p>The record indicated the resident had documented falls on: 06/05/2011,</p>		<p>service plan by the Licensed Nurse. The agreed service plan will be signed and dated by the Resident and, or their Designee. The Licensed Nurse will perform scheduled audits of the Resident service plan. The individual Resident service plans will be reviewed and revised as appropriate ie, needs or desires. The Nursing Director and , or Designee will monitor the Resident service plan. The Resident service plan will be presented at the weekly Resident Care Meeting to ensure needs and desires of the Resident are addressed.</p>				

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	<p>06/10/2011, 06/15/2011, 06/29/2011, 07/22/2011, 09/18/2011, 11/11/2011, 11/17/2011, 11/20/2011, 12/16/2011, and 12/17/2011.</p> <p>Fall risk assessment dated 07/08/2011 indicated Resident #17 had intermittent confusion, 3 or more falls in the past 3 months, required assistance with toileting, had a balance problem while walking and required the use of assistive devices. Resident #17 was scored as a high fall risk</p> <p>A physical therapy referral screening form dated 11/18/2011 indicated, "...recommendations: resident needs A [assistance] +1 &amp; use of RW [rolling walker] c [with] all mob [mobility] secondary poor safety. Toileting schedule. Keep RW near resident at all times so resident can reach...</p> <p>A physical therapy referral screening form dated 11/21/2011 indicated "...recommendations: toileting schedule, Needs RW within reach (was out of residents reach in dining rm [room] this AM when spoke resident). Needs A+1 for all mob &amp; ADL's [activities of daily living] secondary to poor safety awareness...".</p> <p>An individual service plan dated</p>						

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	<p>November 2011 indicated, "...Area of Need/Assistance: Safety: I sometimes will forget to use my walker, especially at night. My gait is unsteady at times even with my walker. I am a fall risk... Goal/Intervention/Approach: Staff will remind me to use my walker. They will assist me with toileting routinely to decrease my risk of falling....Area of Need/Assistance: Mobility: Up and Ad lib with walker, with frequent observation from staff of my whereabouts due to my risk of falls....Goal/Intervention/Approach: Staff will observe and notify therapy of any changes in my gait and refer me as needed. They will keep my walker close to me to remind me to use it, they will monitor my whereabouts frequently and toilet me on a routine basis due to my risk of falls...".</p> <p>The record lacked documentation of the suggested interventions, an updated Fall Risk Assessment, and an updated service plan.</p> <p>The record lacked documentation of the use of alarms for Resident #17.</p> <p>An interview with the DON on 12/20/11 at 1:40 P.M., indicated the facility has a fall meeting every month that is attended by the resident's physician, physical</p>			

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	<p>therapy and the DON. She indicated the facility is restraint free but they do use alarms sometimes. The DON indicated they had tried alarms on Resident #17 but the resident had taken them off and hid them. "...The alarms just didn't work with him..." The DON also indicated Resident #17 was started on Neurontin (anti-anxiety, nerve medication) but it was too strong so he was switched to Depakote (mood stabilizer). The resident has been experiencing increased anxiety, especially at night.</p> <p>An interview with the ED on 12/20/2011 at 2:45 P.M., indicated there were no updated service plans.</p> <p>A CNA assignment sheet provided by the ED on 12/20/11 at 3 P.M., indicated resident ambulates with a walker, and is sometimes a standby assist. The resident requires toileting and observation every 2 hours.</p> <p>A current facility policy provided by the DON on 12/20/2011 at 8:50 A.M., titled, "Fall Risk and Post Fall Assessment (undated) indicated "...Post fall assessment will be performed after each fall and additional interventions promptly initiated to prevent future falls, when possible... Procedure: ...7. If the fall Prevention Plan was ineffective, initiate</p>			

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R0273	<p>an immediate new intervention, and evaluate for need for comprehensive care....repeated falls may indicate a cognitive or mobility status change....9. Document assessment findings, change in fall prevention interventions and physician/family notification in the nurses progress notes...10. complete new or update fall/risk assessment...14. Revise care/service plan to include all new fall interventions....".</p> <p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review the facility failed to ensure safe food handling as evidenced by improper hand washing in the kitchen and food service area, improper glove use in the kitchen and food service area, and no open dates on stored refrigerated foods which had the potential to affect 27 of 27 residents.</p> <p>Findings include:</p> <p>1. During an observation on 12/19/11 at 10:45 a.m., the refrigerator in the main floor dining area contained cheese slices wrapped in plastic wrap with no open date, half of a margarine block wrapped in</p>	R0273	All Personnel was in-serviced 1-18-2012 on proper dating of opened foods ie: bread, refrigerated foods, proper food handling, hand washing, and proper use of gloves.All residents have the potential to be affected by this practice. January 18, 2012 all personnel was in-serviced onProper dating of opened foods ie: bread, refrigerated foods, proper food handling, hand washing, an proper use of gloves, each meal for 1 week.The Dietary Manager will continue to monitor and educate personnel on proper dating of opened foods ie: bread, refrigerated foods, proper food handling, hand washing, and proper use of gloves 1 meal per week ie. Breakfast, Lunch, and	01/31/2012			

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	<p>the original wrapper with no open date, an individual-sized bowl of fruit uncovered and undated, 5 loaves of bread opened with no open date, 1 package of hamburger buns opened with no open date, 1 pitcher of red beverage undated and 1 pitcher of orange juice undated. In the freezer compartment was a large barrel of ice cream opened with no open date.</p> <p>During an interview on 12/19/11 at 10:00 a.m., the Dietary Manager (DM) indicated the refrigerators on the units store food and beverages for resident use.</p> <p>During an interview on 12/19/11 at 11:55 a.m., Resident Care Specialist (RCS) #5 indicated that the night shift staff restocks the refrigerators on the units and dates the items.</p> <p>2. During the lunch observation on 12/19/11 at 11:30 a.m., the DM washed hands and donned gloves. The DM used a scoop to serve mechanical soft meat on 4 resident plates, the DM used a scoop to serve stuffing on these 4 resident plates, the DM used a kitchen utensil to serve green beans on these 4 resident plates, and the DM used a kitchen utensil to ladle gravy over the stuffing on these 4 resident plates. The DM pulled foil and covered each plate. The DM then retrieved a</p>		Dinner for 30 days to ensure the practice does not recur. The results of the monitoring will be presented in the Director's Meeting weekly.		

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	<p>package of buns and reached in with same gloved hands and pulled out two buns to plate on 2 resident plates.</p> <p>During an interview on 12/19/11 at 12:00 p.m., the DM indicated staff should change gloves between chores. The DM indicated staff should use new gloves or tongs when touching food.</p> <p>3. During the lunch observation on 12/19/11 at 11:45 a.m., Dietary Aide (DA) #6 was observed entering the kitchen with gloves on, left the kitchen and retrieved a cart, re-entered kitchen with the cart and loaded the steam trays containing resident food onto the cart. Did not wash hands or change gloves between tasks. DA #6 then took gloves off and retrieved a wash cloth from a bucket of cleaning water and left the kitchen holding the rag and pushing the cart of steam trays out of the kitchen. The DA #6 re-entered the kitchen and opened a can of vegetable drink and poured it into a pitcher. The DA #6 walked away from the pitcher, opened the lid of the trash can, picked up a piece of foil off of the floor and threw it in the trash can and then proceeded to wash hands. Hands were washed for less than 20 seconds.</p> <p>During an interview on 12/19/11 at 12:00 p.m., the DM indicated staff should wash</p>			

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NAME OF PROVIDER OR SUPPLIER  GREEN TREE AT POST ROAD				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN46219			
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	<p>hands when coming in and out of the kitchen and when changing tasks.</p> <p>4. During observation of the downstairs unit's kitchenette area and dining room on 12/19/11 from 11:00 A.M. to 12:15 P.M., the following observations were made:</p> <p>RCS (Resident Care Specialist) #3 was in the dining room, took a plate and paper placemat away from Resident #11 who was licking the plate and has a history of eating paper products, gave the resident a hug, then moved back into the kitchen area and picked up a dish of coleslaw which she handed to RCS #4 to deliver to Resident #10. RCS #3 then returned to the dining room to hug and comfort Resident #11 who was up wandering the dining room. Resident #11 was assisted back to her seat at the table, and RCS #3 returned to the kitchen area to retrieve a bowl of beets for Resident #11.</p> <p>RCS #3 then left the kitchen and dining area, and returned to the kitchen in a minute. At this time, RCS #3 poured a cup of coffee for Resident #7, adding a packet of sugar and stirring it prior to giving it to the resident. RCS #3 was speaking to RCS #4 while in the dining room, coughed in her hand, picked up the telephone, hung up and left the kitchen to go to the main kitchen.</p>						

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	<p>RCS #3 returned to the kitchen, washed her hands for 10 seconds, put oven mitts on, and poured hot water into the steam table openings. RCS #3 then left the kitchen again and returned in a few moments with a box of disposable gloves. RCS #3 then put gloves on, patted her clothes as her phone was ringing. RCS #3 proceeded to take clean bowls and scoops from drawers and cabinets for the lunch service. RCS #3 removed the gloves, went to the hallway bathroom and washed her hands, wearing her apron.</p> <p>RCS #3 returned to the kitchen, put gloves on, handed a clip board and pen to RCS #4 and proceeded to take food temperatures, RCS #4 recorded the temperatures. After taking the food temperatures, RCS #3 placed meats on platters, vegetables and dressing in bowls, and gravy in a pourable container to be served to the residents.</p> <p>A facility policy received by the Director of Nursing on 12/20/11 at 8:40 a.m. titled, "Dietary Services New Employee Training," indicted, "...Proper hand washing is the most critical aspect of personal hygiene. Dietary employees must wash their hands before starting work and after:...Before putting on gloves and after removing them...Touching</p>			

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R0357	<p>anything that may contaminate hands...Wash at least 20 seconds in water...Leftover food is stored in covered containers or wrapped carefully and secure. The food must be clearly labeled on the day it was prepared or opened and marked to indicate the date by which it shall be consumed or discarded. Refrigerator temperatures should be between 35-40 degrees Fahrenheit...Hands must be washed prior to putting on gloves and when gloves are removed...Gloves are like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed and hands washed...Utensils, cups, glasses and dishes are to be handled in such a way as to avoid touching surfaces with which food or drink will come in contact...."</p> <p>(j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to ensure disposition of</p>	R0357	Resident #50 is deceased.All Residents have the potential for this practice. The Licensed	01/31/2012	

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	<p>belongings was documented after a resident's death for 1 of 1 residents reviewed for disposition of belongings (Resident #50).</p> <p>Findings include:</p> <p>The record for Resident #50 was reviewed on 12/19/11 at 2:00 P.M.</p> <p>Diagnoses included, but were not limited to, unspecified psychosis, advanced dementia, hypothyroid, anorexia, chronic pain, and hypertension.</p> <p>Resident #50 died on 11/5/11.</p> <p>The record lacked documentation of what happened to the personal belongings after the resident passed away.</p> <p>During an interview with Administrator on 12/20/11 at 11:15 A.M., she indicated the DON (Director of Nursing) had recently been to an inservice where the attendees had been advised disposition of belongings was no longer required. At that time a copy of this information was requested.</p> <p>During interview with the DON on 12/20/11, she provided information indicating an inventory sheet was no longer required, so they had not</p>		<p>Nursing note, upon death of a Resident, will include the disposition of the Resident's personal belongings. The Licensed Nursing personnel was in-serviced January 18, 2012 on the documentation of the disposition of personal belongings upon the death of a Resident. The Nursing Director or Designee will monitor each Chart upon the death of a Resident and will check the documentation for disposition of the Resident's personal belongings. The findings will be presented at the Director's Meeting weekly as appropriate.</p>				

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	documented disposition of belongings.				