

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2015
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NAME OF PROVIDER OR SUPPLIER GREENBRIAR VILLAGE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219
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R 000 Bldg. 00	<p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: April 13 & 14, 2015</p> <p>Facility number: 011799 Provider number: 011799 AIM number: N/A</p> <p>Census bed type: Residential: 98 Total: 98</p> <p>Census payor type: Medicaid: 6 Other: 92 Total: 98</p> <p>Sample: 10</p> <p>These state deficiencies are cited in accordance with 410 IAC 16.2-5.</p>	R 000		
R 148 Bldg. 00	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and</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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	<p>implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure chemicals and sharp objects were kept secured on the locked dementia unit. This had the potential to affect 1 of 1 independently mobile, cognitively impaired resident on the dementia unit. (Resident #522)</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the Maintenance Director on 4/14/15, at 10:05 a.m. An unlocked supply closet was observed on the 2nd floor of the locked dementia unit. Three bottles of nail polish remover and 12 bottles of nail polish were observed inside the closet. A blue disposable razor was observed inside the top right drawer of the 2nd floor locked dementia unit kitchen area, adjacent from the unlocked supply closet. Resident #522 was</p>	R 148	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All areas containing hazardous materials have been locked and secured. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; One resident had the potential to be affected by the deficient practice. The item was removed and locked according to policy. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All employees of Greenbriar Village were educated on proper storage of hazardous and sharp objects/chemicals April 20, 2015. How the corrective action(s) will be monitored to ensure the</p>	05/06/2015			

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R 155 Bldg. 00	<p>observed sitting in the kitchen area, with no staff supervision.</p> <p>An interview was conducted with the Maintenance Director at this time. He indicated the razor should not be in the drawer and didn't know why it was.</p> <p>The Safety and Security policy was provided by the Executive Director on 4/14/15, at 1:15 p.m. It indicated, "Hazardous areas will be identified and locked as appropriate to ensure resident safety. Locked areas will include at least the following: Supply rooms....All chemicals and hazardous equipment shall be properly stored in a secure area or cabinet to prevent resident or staff incidents."</p> <p>410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure a trash can was covered in the kitchen area during random observations for 1 of 2 kitchen trash cans. This had the</p>	R 155	<p>deficient practice will not recur, i.e., who is responsible, the system by which the responsible person will monitor, the frequency of monitoring, a specific time frame (weekly, monthly, etc.) If the monitoring is for 6 months or less explain the criteria or threshold the QA program will use to determine if further monitoring is necessary or if the monitoring can be stopped; and The Safety Director/Director of Maintenance or Designee will monitor areas that contain the storage of hazardous materials. The frequency of monitoring will be weekly and further monitoring will be ongoing. By what date the systemic changes will be completed. These changes will be complete by May 6, 2015.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All dietary staff will ensure that trash cans will</p>	05/06/2015			

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	<p>potential to affect 98 residents that reside in the facility.</p> <p>Findings include:</p> <p>On 4/13/15 at 11:02 a.m., during a kitchen observation, a trash can in the kitchen dishwashing area was observed to be uncovered and no facility staff were observed to be in the area.</p> <p>On 4/13/15 at 11:09 a.m., during an interview, the Dietary Manager indicated the trash can in the dishwashing room area was "usually uncovered."</p> <p>On 4/14/15 at 9:45 a.m., during an observation and interview, Dietary Employee #4 was observed working near in the dishwasher room next to the uncovered trash can referenced above. The employee indicated having been an employee of the facility for "about 9 months" and having never used a cover for the above referenced trash can since she has been employed at the facility.</p> <p>A facility policy titled "Trash Receptacles and Removal", undated, was received from the Dietary Manager on 4/13/15 at 2:34 p.m. The policy indicated "...All Trash cans must have proper fitting lids..." and "...Trash cans in kitchen must be covered unless they are being used in</p>		<p>becovered unless being used during production. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice. The corrective action will be to in-service all dietary staff on the policy regarding trash cans and utilizing properly fitting lids. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All current kitchen associates as well as new kitchen associates to Greenbriar Village will be educated/in-serviced on the policy regarding trash cans and the utilization of properly fitting lids. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., who is responsible, the system by which the responsible person will monitor, the frequency of monitoring, a specific time frame (weekly, monthly, etc.) IF the monitoring is for 6 months or less explain the criteria or threshold the QA program will use to determine if further monitoring is necessary or if the monitoring can be stopped; and The Kitchen</p>	

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R 187 Bldg. 00	<p>production..."</p> <p>410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.</p> <p>Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 and 120 degrees Fahrenheit, at point of contact, for 5 of 13 residents whose rooms were observed for appropriate water temperatures. (Residents #24, 55, 63, 336, and 410)</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the Maintenance Director on 4/14/15, at 10:05 a.m. The following water temperatures were retrieved by the Maintenance Director:</p> <p>Residents #63 and #410's bathroom sink</p>			R 187	<p>Manager or Designee will be responsible for ensuring the deficient practice does not recur, weekly monitoring will take place to ensure the policy is adhered to, monitoring will be ongoing. By what date the systemic changes will be completed. The systemic changes will be completed by May 6, 2015.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; An outside service provider was contacted to assist in correcting the temperatures outside of 100-120F. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Director of</p>		05/06/2015

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	<p>= 129 degrees Fahrenheit Resident #24's bathroom sink = 122 degrees Fahrenheit Resident #336's bathroom sink = 131 degrees Fahrenheit Resident #336's kitchen sink= 131 degrees Fahrenheit Resident #55's bathroom sink = 130 degrees Fahrenheit Resident #55's kitchen sink = 130 degrees Fahrenheit</p> <p>Monthly water temperature logs were provided by the Maintenance Director on 4/14/15, at 1:30 p.m. The logs did not include any readings from resident rooms, only temperatures directly from the water heater. The log indicated the 4/10/15 temperature from the dementia unit water heater was 135 degrees Fahrenheit.</p> <p>An interview was conducted with the Maintenance Director on 4/14/15, at 12:15 p.m. He indicated the temperatures in the logs were temperatures directly from the water heaters, not resident rooms. He indicated he took resident room water temperatures, but did not document them.</p> <p>The above resident room water temperatures were retested with the Maintenance Director on 4/14/15, at 2:01</p>		<p>Maintenance will collect water temperatures from the seven sources of weekly, taking at least seven water temperatures weekly and ensuring readings are within 100-120F. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., who is responsible, the system by which the responsible person will monitor, the frequency of monitoring, a specific time frame (weekly, monthly, etc.) If the monitoring is for 6 months or less explain the criteria or threshold the QA program will use to determine if further monitoring is necessary or if the monitoring can be stopped; and The Director of Maintenance or Designee will monitor water temperatures weekly to ensure the deficient practice does not recur. Weekly temperatures will be acquired from each source of origination, totaling seven temperatures weekly. This system of monitoring will be ongoing. By what date the systemic changes will be completed. These systemic changes will be completed by May 6, 2015.</p>	

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R 240	<p>p.m. as follows:</p> <p>Resident #63 and 410's bathroom sink = 116 degrees Fahrenheit Resident #24's bathroom sink = 124 degrees Fahrenheit Resident #24's kitchen sink = 124 degrees Fahrenheit Resident #336's bathroom sink = 82 degrees Fahrenheit Resident #336's kitchen sink = 83 degrees Fahrenheit Resident #55's bathroom sink = 85 degrees Fahrenheit Resident #55's kitchen sink = 127 degrees Fahrenheit</p> <p>The Maintenance Policy was provided by the Executive Director on 4/14/15, at 1:15 p.m. It indicated, "It is the policy of Samara Memory Care at Green Tree Post Road to provide a safe, accessible, effective and efficient environment of care that is consistent with its mission, services and law and regulations."</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency</p>				

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Bldg. 00	<p>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on interview and record review, the facility failed to obtain weekly weights, as ordered, for 1 of 7 residents reviewed for following physician's orders. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 4/13/15, at 11:00 a.m. The diagnoses for Resident #7 included, but were not limited to, dementia.</p> <p>The 3/12/15 Physician's Order for Resident #7 indicated weight to be obtained weekly, for 4 weeks, every Thursday, due to weight discrepancy/fluctuation. The 3/26/15 hospice nursing note indicated a weight of 128 pounds. The April, 2015 MAR (medication administration record) indicated a weight of 123 pounds on 4/9/15. There was no information in the clinical record to indicate a weekly weight was obtained for Resident #7 the weeks of 3/19/15 and 4/2/15.</p> <p>An interview was conducting with the Nursing Director on 4/14/15, at 9:25 a.m. She indicated the only weights she could find after Resident #7's 3/12/15 order for</p>	R 240	<p>deficient practice; The Licensed staff will follow policy with regard to physician orders with an emphasis on following orders as written, the inconsistency as it related to weekly weights was addressed in a nurse's meeting held on 4-22-15. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice. The corrective action will be to educate and in-service the Licensed staff on policy as it relates to following physician orders. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Director of Wellness or Designee will randomly monitor for compliance the MAR's will be reviewed weekly, any discrepancies will be reported to the Director of Wellness. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., who is responsible, the system by which the responsible person will</p>	05/06/2015

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R 273 Bldg. 00	<p>weekly weights, were the 3/26/15 and 4/9/15 weights. She indicated she had a call out to the physician to inform of the missing weights.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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. Based on observation, interview, and record review, the facility failed to ensure 2 employees had facial hair restrained during random observations. This had the potential to affect 98 residents that reside in the facility.</p> <p>Findings include: On 4/13/15 at 11:00 a.m., during a kitchen observation, Dietary Employee #5 was observed preparing pasta in the</p>	R 273	<p>monitor, the frequency of monitoring, a specifictime frame (weekly, monthly, etc.) IF the monitoring is for 6 months or less explain the criteria or threshold the QA program will use to determine if further monitoring is necessary or if themonitoring can be stopped; and The Director of Wellness of Designee will be reviewing the MAR's on a weekly basis which will serve as an ongoing practice. By what date the systemic changes will be completed. The systemic changes will be completed by May 6, 2015.</p> <p>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice; The facility policy has been updated to reflect facial hair. All dietary and non-dietary staff will follow the policyentitled "Kitchen Hairnet Use" when in production areas</p> <p>How the facility willidentify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken;</p>	05/06/2015			

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	<p>kitchen food preparation area. He had facial hair, a beard, on his chin and jaw area which was not covered by a hair restraint. He was observed working directly above a bowl of pasta which was uncovered.</p> <p>On 4/13/15 at 11:09 a.m., during an interview, the Dietary Manager indicated "We (the dietary department) don't have any employees who require a beard cover."</p> <p>On 4/13/15 at 11:48 a.m., during an observation, Dietary Employee #6 was observed entering the kitchen area with a cart of pitchers. He was heard talking to another staff member and indicated he was "getting some ice." He took the cart into the kitchen food preparation area without a facial hair restraint to cover his observable beard hair.</p> <p>On 4/14/15 at 10:07 a.m., during an interview, the Dietary Manager indicated "I didn't know his (Dietary Employee #5) beard was that long." She also indicated any employee who had facial hair should wear a facial hair restraint prior to entering the kitchen area.</p> <p>A facility policy titled "Kitchen Hair Net Use", undated, was received from the Dietary Manager on 4/13/15 at 2:34 p.m.</p>		<p>All residents have the potential to be affected by the deficient practice. The corrective action will be to in-service all staff on the proper attire necessary for entering the kitchen production areas to include hairnets and facial hair restraints.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All current associates as well as new associates to Greenbriar Village will be educated/in-serviced on the "Kitchen Hair Net Use" policy to include the use of facial hair restraints, signage has also been posted to kitchen doors as a reminder of the policy.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., who is responsible, the system by which the responsible person will monitor, the frequency of monitoring, a specific time frame (weekly, monthly, etc.) IF the monitoring is for 6 months or less explain the criteria or threshold the QA program will use to determine if further monitoring is necessary or if the monitoring can be stopped; and The Kitchen Manager or Designee will be responsible for ensuring the deficient practice does not recur, weekly monitoring will take place to ensure the policy is adhered to, monitoring will be ongoing.</p>	

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	The policy indicated "...Prior to entering the kitchen/food preparation area, staff will place a hair net on their head to cover all hair..."				<p>By what date the systemic changes will be completed.</p> <p>The systemic changes will be completed by May 6, 2015.</p>		