

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 03/12/2012
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227
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R0000	<p>This visit was for the Investigation of Complaint IN00103841.</p> <p>Complaint IN00103841 - Substantiated. State residential findings related to the allegation are cited at R052, R090 and R409.</p> <p>Survey dates: March 09 and 12, 2012</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Survey team: Kimberly Perigo, RN</p> <p>Census bed type: Residential: 64 Total: 64</p> <p>Census payor type: Other: 64 Total: 64</p> <p>Sample: 34</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/15/12 by Suzanne</p>	R0000		

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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	Williams, RN			

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R0052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interviews and record reviews, the residential facility failed to ensure residents were free from sexual abuse for 1 of 2 residents [Resident E] reviewed for sexually acting out behaviors in that two residents were repeatedly touched in an unwanted and/or inappropriate manner, in a sample of 34 residents. [Resident A and Resident I] This State Residential Finding had the potential to affect 19 residents who resided on the Memory Care Unit.</p> <p>Findings include:</p> <p>During the initial tour of the Memory Care Unit on March 09, 2012 from 11:00 a.m. to 11:30 a.m.; the Executive Director indicated Resident E was not at the residential facility, due to Resident E having had, "problems with boundaries with other residents."</p> <p>Alpha List by Property [record of census] dated March 09, 2012; provided by the Executive Director, indicated nineteen</p>	R0052	<p>R052:</p> <ol style="list-style-type: none"> Resident E was discharged on 2/24/12. No other residents were affected by the alleged deficient practice per audit of residents on Memory Care Neighborhood conducted by Resident Care Director on 2/24/12. Staff will be In-Serviced on 4/6/12 by Resident Care Director regarding managing and monitoring behaviors, reporting procedures for behaviors and documenting procedures on the 24 hour report and in resident records. Resident Rights In-service to be conducted by Cynthia McQuigg, the ombudsman on April 6 th , 2012. Residents who exhibit inappropriate behaviors will be redirected upon 	04/06/2012			

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	<p>residents resided on the Memory Care Unit.</p> <p>Resident E's record was reviewed on March 09, 2012.</p> <p>Resident E's diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>A Resident Baseline & Data Set dated November 11, 2011 [preadmission assessment], indicated; "...Resident has been evaluated and is independent in mobility. ... Oriented to person, periods of confusion. ... Resident has periods of confusion/forgetfulness. Requires occasional reminders to find areas within the community...."</p> <p>Service Notes indicated, "2/8/12 10p ... Resident many inappropriate sexual behaviors in front of other residents. Was in dining room et [and] took off all his clothes, walking around naked. ... 2/9/12 5A ... resident trying to grab female staff et other residents. Also, ... resident in front of another male resident attempting to masturbate, manipulate his genitalia. Will report to supervisor ... 2/10/12 5 AM Resident continues to try to take female residents into his room. Kissing female resident on mouth. Very inappropriate behaviors. Staff will cont. to monitor and ensure safety of other resident. Placed on 24 beh [24 hour behavior monitoring]. ...</p>		<p>recognition but behaviors in violation of residents' rights that require repeated redirection or can not be redirected will be transferred to a medical facility or mental health facility, for evaluation and treatment. Residents will be evaluated prior to return to determine if resident meets admission requirements.</p> <p>4. The RCD will be responsible for sustained compliance. The RCD and/or designee will randomly review resident records 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then once a week. Audit results will be discussed in quarterly Quality Assurance meetings. The QA Committee will determine if continued auditing is necessary. The Regional team will randomly review during routine visits and during the Annual Comprehensive Process Review.</p> <p>5. These systemic changes will be completed by April 6 th</p>				

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	<p>2/11/12 10 pm Resident wandering around hallways. Conts to kiss on residents. Will cont. to monitor. 2/11/12 11:45 pm ^ [up] wandering in halls, RA [employee #1] found resident touching breasts of another female resident while she was sitting on a couch. RA redirected resident to return to his room ... Will continue to monitor closely. [sic]"</p> <p>Employee #1 was interviewed on March 12, 2012 at 11:15 a.m. During the interview employee #1 indicated having observed Resident E touch Resident I's breast, on the outside of her clothing, with his hand. Employee #1 further indicated Resident E's behaviors, "occur almost every day and we have to keep him away from the ladies."</p> <p>Resident I's record was reviewed on March 12, 2012 at 10:20 a.m. Resident I's diagnoses included, but were not limited to, dementia. A Note to physician indicated, "Date event occurred 2/11/12. Provide a brief description of the event: 2/11/12 Resident rights were violated by another resident [Resident E] who was touching her breast. A follow up physician note dated February 28, 2012 indicated, "... she provides no verbal feedback ... physical assault - sexual in nature but brief."</p>		, 2012.	

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	<p>Continued review of Resident E's Service Notes indicated, "2/12/12 9 pm Resident conts. to touch and kiss female residents. Have to redirect instantly. Will cont. to monitor. ... 2/24/12 4 am Resident conts. to exhibit behaviors ... 2/24/12 9:30 A Writer was changing another res _____ [Resident E's name] kept coming in res. room. ...[sic]"</p> <p>Resident A's clinical records were reviewed on March 09, 2012 at 12:50 p.m. Diagnoses included, but were not limited to, dementia. A Note to physician dated February 22, 2012 indicated, "Resident's right was violated by another resident [Resident E] who tried to kiss and grope her in the dining room."</p> <p>Employee #2 was interviewed on March 12, 2012 at 11:25 a.m. During the interview employee #2 indicated having observed Resident E walk up to Resident A "grab her boobs and kiss her." Employee #2 indicated Resident E had "groped and kissed" Resident A, and at times she would tell him to leave her alone and "he wouldn't stop."</p> <p>Two Incident Reports provided by the Executive Director on March 09, 2012 at 3:30 p.m. indicated:</p> <p>"Incident Date: February 11, 2012.</p>			

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	<p>Incident Time: Between 10:00 p.m. and 11:00 p.m. Resident Involved: _____ [Resident E's name]. ... Brief Description of Incident: _____ [Resident E's name] was found touching the breasts of _____ [Resident I's name] while they were sitting on the couch. ..."</p> <p>"Incident Date: February 22, 2012. Incident Time: Between 11:30 a.m. and 12:30 p.m. Resident Involved: _____ [Resident E's name]. ... Brief Description of Incident: While in the dining room, every time _____ Resident E's name] walked past _____ [Resident A's name] or Resident I's name, he kisses or gropes them. This occurred twice with _____ [Resident A's name] and once with _____ [Resident I's name]. ..."</p> <p>Resident E's clinical records indicated he was discharged from the residential facility on February 24, 2012.</p> <p>The Residential Facility's Abuse Prevention Policy dated May 10, 2011; provided by the Executive Director of March 12, 2012 at 11:40 a.m. indicated, "Policy: To protect residents from ... sexual ... abuse ... Definitions: ... Sexual Abuse is any form of non-consensual contact including but not limited to unwanted or inappropriate touching ..."</p>			

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	This State Residential Finding relates to Complaint IN00103841.				

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interviews and review of records, the residential facility failed to inform the division within twenty-four hours of becoming aware of an unusual occurrence for 2 of 2 unusual occurrences reviewed that had the potential to directly threaten the welfare and safety of 19 residents. [Resident A and Resident I]</p> <p>Findings include:</p> <p>Two Incident Reports provided by the Executive Director on March 09, 2012 at 3:30 p.m. indicated:</p> <p>"Incident Date: February 11, 2012. Incident Time: Between 10:00 p.m. and 11:00 p.m. Resident Involved: _____ [Resident E's name]. ... Brief Description of Incident: _____ [Resident E's name] was found touching the breasts of _____ [Resident I's name] while they were sitting on the couch. ..."</p> <p>"Incident Date: February 22, 2012. Incident Time: Between 11:30 a.m. and 12:30 p.m. Resident Involved: _____</p>	R0090	<p>R090:</p> <ol style="list-style-type: none"> The Executive Director responsible for reporting of the incident to the State is no longer an employee at the facility. No other residents were affected by the alleged deficient practice, per audit of current residents residing on Memory Care Neighborhood, completed by Resident Care Director on 2/24/12. The staff will be in-serviced on 4/6/12 by Executive Director to review the procedure for reporting events to the supervisors, and include reporting events to ISDH. The ED will use the Indiana State Department of Health Reportable Guidelines to report required reportable events. The Executive Director will be responsible for 	04/06/2012

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	<p>[Resident E's name]. ... Brief Description of Incident: While in the dining room, every time _____ [Resident E's name] walked past _____ [Resident A's name] or Resident I's name, he kisses or gropes them. This occurred twice with _____ [Resident A's name] and once with _____ [Resident I's name]. ..."</p> <p>An Event Management and Reporting Policy dated August 26, 2011; provided by the Executive Director on March 12, 2012 at 11:10 a.m. indicated, "... Upon discovery of an event: Executive Director, Resident Care Director, or designee, shall submit an Event Management Report within 24 hours of event or the next business day."</p> <p>Documentation of Event Reporting indicated the above events had been reported to the Indiana State Department of Health on February 28, 2012. Seventeen days after the incident dated February 11, 2012 and six days after the incident dated February 22, 2012.</p> <p>During interview on March 12, 2012 at 10:15 a.m.; the Executive Director indicated the events dated February 11 and 22, 2012 had not been reported within twenty-four hours as indicated by their policy.</p>		<p>sustained compliance. The RCD and/or designee will monitor events to identify need for further reporting if indicated, to the state agency. Events will be reviewed in quarterly Quality Assurance meetings, and the Quality Assurance Committee will determine if continued QA review is necessary after 3 consecutive quarters of compliance. The Regional team will randomly review during routine visits and during the Annual Comprehensive Process Review.</p> <p>5. These systemic changes will be completed by April 6 th , 2012</p>	

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R0409	<p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interviews and review of records, the facility failed to show that residents had no evidence of tuberculosis in an infections stage in that annual tuberculosis testing could not be verified for 24 residents of 34 sampled residents. [Resident K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, and HH]</p> <p>Findings include:</p> <p>Review of residential records on March 09, 2012; indicated twenty-four residents who resided at the residential facility lacked documentation of having received annual [2011] tuberculosis testing. The most recent documentation indicated annual tuberculosis testing completed August 2010. (Residents: K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, and HH.)</p> <p>Resident Tuberculosis Testing dated February 15, 2010; provided by the</p>	R0409	<p>R409:</p> <ol style="list-style-type: none"> Annual PPD testing was completed on 3/27/12 by Resident Care Director and Nursing Designee for residents K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH. An audit of resident charts to identify if any other residents are missing records of PPDs was completed by Nursing Staff on March 12. No other residents were affected by the alleged deficient practice. Licensed nursing staff will be in-serviced on Annual PPD testing requirements on 3/6/12 by Resident Care Director. Annual PPD results will be recorded in the resident record by licensed staff. The RCD will be responsible for sustained 	04/06/2012			

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	<p>Executive Director on March 12, 2012 at 11:10 a.m., indicated residents were to receive annual tuberculosis testing. The testing would identify a resident with active tuberculosis.</p> <p>Interview with the Executive Director and Resident Care Director on March 12, 2012 at 10:15 a.m. indicated the twenty-four identified residents did not have documentation which would indicate having received an annual tuberculosis testing.</p> <p>This State Residential Finding relates to Complaint IN00103841.</p>		<p>compliance. The RCD will randomly audit resident records for current residents weekly for 4 weeks, then bi-monthly for 4 weeks, then monthly. PPD audit reviews will be ongoing. Audit results will be discussed in quarterly Quality Assurance meetings. The Regional team will randomly audit during routine visits and during the Annual Comprehensive Process Review.</p> <p>5. These systemic changes will be completed by April 6 th , 2012.</p>				