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| 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 04/09/2014 |
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| NAME OF PROVIDER OR SUPPLIER GREEN TREE AT POST ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219 |
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| R000000 | <p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: April 8-9, 2014</p> <p>Facility number: 011799 Provider number: 011799 AIM number: N/A</p> <p>Survey team: Beth Walsh, RN Courtney, Mujic, RN Karina Gates, Generalist Tom Stauss, RN</p> <p>Census bed type: Residential: 40 Total: 40</p> <p>Census payor type: Other: 40 Total: 40</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on April 11, 2014 by Cheryl Fielden, RN.</p> | R000000 | | |
| R000035 | <p>410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including</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>arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.</p> <p>(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement.</p> <p>(4) Refuse any treatment or service, including medication.</p> <p>(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.</p> <p>(6) Be afforded confidentiality of treatment.</p> <p>(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on interview and record review, the facility failed to ensure a resident participated in the development of her service plan for 1 of 3 residents reviewed for service plan participation. (Resident #10)</p> <p>Findings include:</p> <p>The clinical record for Resident #10 was reviewed on 4/9/14 at 10:15 a.m. The</p> | R000035 | R 035 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Director of Wellness has spoken to resident #10 regarding her service plan. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective | 04/25/2014 |

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| | <p>diagnoses for Resident #10 included, but were not limited to, Parkinson's and dementia.</p> <p>A tour of the facility was conducted with LPN #5 on 4/8/14 at 11:30 a.m. During this tour, LPN #5 indicated Resident #10 was interviewable.</p> <p>During an interview with the Director of Wellness, on 4/9/14 at 9:45 a.m., she indicated Resident #10 was interviewable.</p> <p>An interview was conducted with Resident #10 on 4/9/14 at 10:30 a.m., regarding whether she participated in the development of her service plan. She stated, "I don't recall ever doing that." Regarding whether she would like to be involved when staff discuss and plan the services she receives at the facility, she indicated, "That would be nice." She indicated she would also like to have her daughter with her for the discussions and planning.</p> <p>The Signature Pages of the March, 2014, December, 2013 and October, 2013 Individual Service Plans for Resident #10 were signed by the DoW only. The Responsible Party/POA signature lines and the Additional Family Member signature lines were blank on all 3 service plans. There were no lines for a resident's signature on the Signature Pages.</p> <p>An interview was conducted with the DoW on 4/9/14 at 11:00 a.m., regarding whether residents, including Resident #10, participated in the development of service plans. She stated, "No, they don't. They have dementia. No, (name of Resident #10) doesn't. I guess we could start involving her</p> | | <p>action will be taken; All residents have the potential to be affected by the deficient practice. The corrective action will be to enact a formal process to communicate to residents and their representative as to when their service assessment review will take place. 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. Any discrepancies will be resolved by holding a meeting with the resident and representative and obtaining signatures. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and This system will be reviewed by the Director of Wellness or Designee during re-writes which occur monthly with monitoring to continue on an ongoing basis. By what date the systemic changes will be completed. May 9, 2014</p> | | | | |

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| R000217 | <p>in the service plan. No, I didn't attempt to involve (name of Resident #10) in her service plan, I'm sorry to say."</p> <p>The DoW provided the Resident Evaluation and Service Plan Policy on 4/9/14 at 11:30 a.m. Standard #9 of the policy indicated, "The Service Plan will be developed and reviewed at the Service Plan Conferences which will be scheduled and take place in accordance with the schedule identified in Standard #1. The Director of Well Being will coordinate the scheduling of Service Plan Conferences and notify all disciplines (as applicable) and the Resident/Legal Representative or other identified family member of the time and date of conferences."</p> <p>An interview was conducted with the Wellness Director on 4/9/14 at 11:35 a.m., regarding whether the facility was following Standard #9 of the Resident Evaluation and Service Plan Policy. She indicated the facility had not been following the policy.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires</p> | | | |

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| | <p>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 interview and record review, the facility failed to ensure a Resident/POA/Responsible Party signed a Service Plan. This affected 6 of 7 residents reviewed for clinical records. (Resident #10, #26, #41, #42, #33, & #4)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #10 was reviewed on 4/9/14 at 10:15 a.m. The diagnoses for Resident #10 included, but were not limited to, Parkinson's and dementia.</p> <p>The Signature Pages of the March, 2014, December, 2013 and October, 2013 Samara Memory Care Individual Service Plans for Resident #10 were signed by the Director of Wellness (DoW) only. The Responsible Party/POA signature lines and the Additional Family Member signature lines were blank on all 3 service plans. There were no lines for a resident's signature on the Signature Pages.</p> | R000217 | <p>R217 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The residents who were identified (10,26,41,4,42,33) will be afforded the opportunity to review their service assessments.</p> <p>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 active will be to follow the formal process inviting residents to plan and review their service assessments. 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 audit monthly</p> | 05/09/2014 |

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| | <p>2. The clinical record for Resident #26 was reviewed on 4/8/14 at 2:00 p.m. The diagnoses for Resident #26 included, but were not limited to, dementia.</p> <p>The Signature Page of the March, 2014 Samara Memory Care Individual Service Plan for Resident #26 was signed by the DoW only. The Responsible Party/POA signature line and the Additional Family Member signature line was blank. There was no line for a resident's signature on the Signature Page.</p> <p>3. Resident #42's clinical record was reviewed on 4/9/2014 at 9:45 am. The resident's diagnoses included but were not limited to, dementia.</p> <p>A Samara Memory Care Individual Service Plan, dated 2/7/2014, indicated it was signed by the DoW, on the Health Manager's line. The document had no signatures for the Responsible Party/POA.</p> <p>4. Resident # 33's clinical record was reviewed on 4/9/2014 at 9:45 am. The resident's diagnoses included but were not limited to, dementia.</p> <p>A Samara Memory Care Individual Service Plan, dated only as "March", indicated it was signed by the DoW. The document had no signatures for the Responsible Party/POA.</p> <p>6. The clinical record for Resident #4 was reviewed 4/8/14 at 1:15 p.m. The diagnoses for Resident #4 included, but were not limited to, dementia, congestive heart failure, hypertension, and glaucoma.</p> <p>A Samara Memory Care Individual Service</p> | | <p>during chart audits. Any discrepancies will be corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and This system will be reviewed by the Director of Wellness or designee on a monthly basis during re-writes with monitoring to continue on an ongoing basis becoming a part of re-writes. By what date the systemic changes will be completed. May 9, 2014</p> | |

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| | <p>Plan for Resident #4 was dated 3/14 and it remained current at the time of review. A review of the Signature Page for the Individual Service Plan indicated a signature for the DoW. There were no signatures on the line for the Responsible Party/POA or on any other line of the Signature Page.</p> <p>During an interview with the DoW, on 4/8/14 at 2:20 p.m., she indicated the Residents typically do not sign their Service Plan due to their cognition level. The DoW indicated on occasion the POA will sign the Service Plan, if they were in the building. She further indicated the facility can start ensuring that the Responsible Party/POA signs the Service Plan as the Responsible Party for the Resident.</p> <p>On 4/9/14, at 10:28 a.m., a policy titled, Resident Evaluation and Service Plan Policy, no date, was received from the DoW. It indicated, "...11. The agreed upon service plan will be signed and dated by the Resident/Legal Representative and facility staff member...."</p> <p>5. Resident # 41's record was reviewed on 4/9/14 at 10:02 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia, hypertension, chronic renal disease, hypothyroidism.</p> <p>A Samara Memory Care Individual Service</p> | | | | | | |

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| R000241 | <p>Plan, dated 12/2013, was observed in the record. It did not have a licensed nurse's signature. It also did not have Resident #41's signature or a responsible party's signature.</p> <p>On 4/9/14 at 12: 19 p.m., the DoW indicated Resident #41's service plan was not signed by a licensed nurse but should have been. She indicated she did not see Resident #41's signature on the document or a responsible party's signature.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>2. Resident #36 's clinical record was reviewed on 4/9/2014 at 11:40 a.m. Diagnoses included but were not limited to; dementia, and gastroesophagael reflux disease.</p> <p>An MD order, dated 1/9/2013, indicated "Increase ferrous sulfate (iron) to 325 mg po (by mouth) TID (three times a day)".</p> <p>An observation, on 4/9/2014 at 11:10 a.m., indicated LPN #1 placed the Resident #36 's ferrous sulfate medication into a plastic bag and crushed it with a pill crusher. The outside of the pill was black in color and when crushed the inside powder was white in color. LPN #1 then poured the crushed medication into a cup and mixed it with applesauce. In an interview during the observation, LPN #1</p> | R000241 | R241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Licensed Staff will follow policy with regard to following physician's orders as written with an emphasis on discontinuing medications. An order was obtained to crush medications for resident #36 and an order to discontinue Aricept was obtained for resident #4. 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 active will be to educate and in-service the | |

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| | <p>indicated "we crush all his medications because he is a mechanical soft diet."</p> <p>A telephone interview, on 4/9/4014 at 11:57 a.m., with the [name of Pharmacy company] Pharmacist indicated, "it could be a little more irritating if its (the ferrous sulfate) crushed, its not a good idea."</p> <p>An interview with the Director of Wellness, on 4/9/2014 at 12:15 p.m., indicated there should be an order for crushing Resident #36's medication. She also indicated she would, "take care of that right away and get an order."</p> <p>Based on interview and record review, the facility failed to ensure there was a Physician's Order to hold a medication for an extended period of time. This affected 1 of 7 residents reviewed for clinical records. (Resident #4) The facility also failed to ensure a MD order was in place to crush a resident's medications for 1 of 4 residents observed for medication administration. (Resident #36)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #4 was reviewed 4/8/14 at 1:15 p.m. The diagnoses</p> | | <p>Licensed staff on the policy for discontinuing a medication as it relates to communications with the physician. 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 monitor weekly for compliance by reviewing MAR's and following up with the physician on any discrepancies. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and This system will be monitored by the Director of Wellness or designee and reviewed during the monthly re-writes with monitoring to continue on an ongoing basis. By what date the systemic changes will be completed. May 9, 2014</p> | |

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| | <p>for Resident #4 included, but were not limited to: dementia, congestive heart failure, hypertension, and glaucoma. Resident #4 was admitted on 3/5/14.</p> <p>The Admission Physician's Orders indicated an order for Aricept (Donepezil-medication of memory loss) 10 milligrams every evening.</p> <p>The March Medication Administration Record (MAR) indicated Aricept was not given for the whole month of March, by the circled initials in all the dated slots, except for the dates 3/18/14 and 3/26/14, which did not have any initials at all in the dated slots for the medication.</p> <p>During an interview with the Director of Wellness (DoW), on 4/8/14 at 2:25 p.m., she indicated the MAR showed that Aricept was not given the whole month of March. She further indicated the medication was held for the entire month, without a Physician's Order.</p> <p>A Nurse's Note, dated 4/4/14 at 9 p.m., indicated, "Writer called family after noticing Aricept 10 mg hadn't been available in cart for over a month. [Name of Daughter] (daughter) stated that it was supposed to be dc'd [discontinued] due to an upset stomach and nightmare [sic] as side effects. Wrote pending order to put medication on hold per family request until doctor okays to d/c. Faxed doctor & told [illegible per DoW] & DoN [Director of Wellness].</p> <p>A fax to the Resident's MD (medical doctor), dated 4/4/14 at 8:32 p.m., indicated the following message, "Resident hasn't been getting Aricept 10 mg since he has been admitted to [Name of Facility Unit]. Family says it gives him nightmares & an upset</p> | | | |

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| R000273 | <p>stomach. Can we have an order to d/c this medicine?" The MD responded back to the fax at 8:55 a.m., on 4/7/14, as indicated by the fax time on the fax. The MD indicated to discontinue the medication.</p> <p>A Physician's Order, dated 4/7/14, indicated to discontinue Aricept 10 mg.</p> <p>At 2:49 p.m., on 4/8/14, the DoW indicated she just spoke with the Resident's MD and he indicated the above Physician's Order can be "back dated" to the Resident's admission of 3/5/14.</p> <p>On 4/9/14, at 9:42 a.m., the DoW indicated she was unable to locate any documentation that the MD was notified prior to 4/4/14 that Aricept was not being given as ordered. The DoW also indicated there should've been an order to hold or to discontinue the medication when the Resident was admitted, if the family desired the medication not be given.</p> <p>A policy titled, Medication/Treatment Administration Record Policy, no date, was received from the DoW on 4/9/14 at 11:17 a.m. It indicated, "...11. Physicians shall be notified of medication/treatments declined by the resident or medication unavailability...." 410 IAC 16.2-5-5.1(f)</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an employee wore a hairnet while in the kitchen</p> | R000273 | R273 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All dietary and non-dietary staff | |

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| 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 04/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER GREEN TREE AT POST ROAD | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>area. This had the potential to affect 40 out of 40 residents.</p> <p>Findings include:</p> <p>On 4/8/14 at 11:29 a.m., during an observation, Facility Receptionist #2 entered the kitchen area without a hairnet. She walked across the kitchen to an unidentified dietary employee and delivered a message to the employee. The employee was immediately next to a food preparation area where the lunch meal was being prepared for facility residents.</p> <p>On 4/8/14 at 11:31 a.m., during an interview, the Dietary Manager indicated she witnessed the receptionist enter the kitchen without a hairnet. She indicated the receptionist "broke our policy" on hair restraints.</p> <p>On 4/8/14 at 1:45 p.m., Facility Receptionist #2 indicated she went into the kitchen on 4/8/14 as the staff were preparing lunch. She indicated she was trying to deliver a message to a staff member. She indicated she did not wear a hair restraint, but that she should have worn a hairnet.</p> <p>A facility policy titled "Kitchen Hair Net Use" indicated the following: "...All non-dietary personnel will wear hair nets if they enter the kitchen/food preparation area..."</p> | | <p>will follow the policy entitled "Kitchen Hair Net Use." 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 all staff on the proper attire necessary for entering the kitchen. 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 Greentree will be educated/in-serviced on the "Kitchen Hair Net Use" policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Dining Director or designee will be responsible for monitoring compliance with the hairnet policy on a daily basis. Any individual who is non-compliant with the policy will be counseled and re-educated. This system will be in place on an ongoing basis. By what date the systemic changes will be completed. May 9, 2014</p> | | | | |