

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2014
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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for the Investigation of Complaints IN00157252 and IN00157308.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00157252 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226, and F371.</p> <p>Complaint IN00157308 - Substantiated. Federal/State deficiencies related to the allegations are cited at F371.</p> <p>Survey dates: October 6, 7, 8, 9, 10, 13, 14, and 15, 2014</p> <p>Facility number: 000145 Provider number: 155241 AIM number: 100275110</p> <p>Survey team: Dorothy Plummer, RN-TC Karyn Homan, RN (October 6, 7, 8, and 9, 2014) Patsy Allen, SW (October 7, 8, 9, 10, 13, 14, and 15, 2014) Marsha Smith, RN (October 6, 7, 8, 13, 14, and 15, 2014)</p>	F000000	Forest Creek Village respectfully requests a face to face IDR for scope and severity of tags F223, F225, and F226	
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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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F000223 SS=D	<p>Census bed type: SNF: 11 SNF/NF: 104 Total: 115</p> <p>Census payor type: Medicare: 17 Medicaid: 77 Other: 21 Total: 115</p> <p>Complaint Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 21, 2014; by Kimberly Perigo, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal</p>			

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	<p>punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents remained free from physical abuse for 1 of 3 residents reviewed for abuse in that after an occurrence of a resident to resident altercation interventions were not put into place, as indicated by facility policy, to prevent a second altercation from occurring, which resulted in a skin alteration. (Residents #C and #D) (CNAs #2, #4, and #5) (Unit Manager #3)</p> <p>Findings include:</p> <p>On 10/8/14 at 4:05 p.m., the Director of Nursing (DON) indicated a resident to resident verbal altercation occurred on 10/4/14, between Resident #C and #D. CNA #2 had overheard the argument and came in the shared residents' room to see what was the matter and found the residents arguing over the light in the room. Resident #C alleged Resident #D had poked her in the chest. The DON indicated she came to the residents' room and had someone take Resident #D to the activity room and she stayed with Resident #C to discuss the need to switch rooms for her safety. The DON continued to indicate Resident #C was very upset and refused to switch rooms. Resident #D's family was called to inform them of the altercation and to see</p>	F000223	<p>Forest Creek Village respectfully requests a face to face IDR for scope and severity of tag F223</p> <p>F 223 FREE FROM ABUSE/INVOLUNTARY SECLUSION--</p> <p>The resident has theright to be free from verbal, sexual, physical, and mental abuse, corporalpunishment, and involuntary seclusion.</p> <p>The facility mustnot use verbal, mental, sexual, or physical abuse, corporal punishment, orinvoluntary seclusion.</p> <p>What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?—</p> <ul style="list-style-type: none"> ·Resident C was evaluated by her attendingpsychiatrist for evaluation. He madeadjustments to the plan of care. Resident #C will continue to be followed by psychiatrist for adjustmentsas needed. Social Services or designee will meet with Resident #C weekly x four weeks to address any behavioralchanges or psychosocial needs. ·ResidentD assessed by Social Services weeklyfor two weeks with no indication of distress or recollection of theincident. Social Services will addressany psychosocial needs as needed. ·Resident C and D remain in separaterooms 	11/03/2014

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	<p>if they would be okay with a room switch. Resident #D's family refused. So the DON called the Social Services director and she indicated Resident #C should move for her safety, since she alleged Resident #D poked her. Resident #C's family was called and informed of the altercation and told Resident #C refused to move rooms. Resident #C's family told the DON they would be in to talk to Resident #C and she can move rooms. At this point Resident #C was told she could not go back to her original room.</p> <p>Review of Resident #C's clinical record on 10/9/14 at 12:00 p.m., indicated the admission MDS (Minimum Data Set) assessment, completed on 9/2/14, assessed Resident #C as having a BIMS (Brief Interview for Mental Status) score of 14, meaning she is cognitively intact. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #D had a "pink/light red" mark in the center of her chest and excoriation under her breast.</p> <p>Review of Resident #D's clinical record on 10/9/14 at 12:15 p.m, indicated diagnoses included, but not limited to, dementia (disorder of mental processes effecting memory, personality, and</p>		<p>·Resident C and D behavior care plans updated</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents who have been involved in resident to resident abuse have the potential to be affected.</p> <p>·IDT will complete a review of all residents who have been involved in resident to resident abuse since October 1, 2014 to ensure appropriate measures have been put in place to ensure resident safety. Any concerns with resident safety will be addressed immediately in the plan of care and with the physician.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·All nursing staff will be re-educated on the facility's Behavior Management Program and Abuse Prohibition policy; including the need to ensure resident safety after a resident to resident altercation.</p> <p>·Re-education will be conducted by DNS and completed by 11/3/14.</p>	

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	<p>reasoning) and Alzheimer's Disease (progressive mental deterioration). The quarterly MDS assessment, completed 7/8/14, assessed Resident #D as having a BIMS score of 4, meaning she has severe cognitive impairment. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #C had a skin alteration on her right great toe.</p> <p>On 10/9/14 at 11:10 a.m., the DON indicated after the altercation she told staff the two residents had to remain separated. There was no specific intervention put in place to ensure they stayed apart, such as fifteen minute checks, one on ones, or designated staff to watch either resident. When the DON left the facility Resident #C was in the activity room and Resident #D was in the residents' room. It had been decided Resident #C was going to move rooms, but they were still waiting on her family to come talk to her.</p> <p>The facility timeline of events that occurred on 10/4/14, was provided by the DON on 10/9/14 at 9:10 a.m. The time line indicated the DON left the facility at 4:30 p.m., Resident #C's family came in to talk with her at 4:30 p.m. and stayed till 5:30 p.m.</p>		<ul style="list-style-type: none"> ·The Director of Nursing Services or designee will be contacted immediately after each resident to resident abuse situation. The DNS or designee will work with the staff member to develop an intervention that ensures resident safety. ·All new/worsening behaviors will be reviewed by the interdisciplinary team for a thorough review of the behavior, assessment of potential contributing factors, root cause and implementation of intervention. The interdisciplinary team will review each resident to resident abuse situation and ensure that there are interventions in place to ensure resident safety. ·Corporate consultant will also review all resident to resident abuse incidents to ensure interventions for resident safety are maintained. <p>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?</p> <ul style="list-style-type: none"> ·SS/designee will be responsible for the completion of the Resident to Resident Altercations and Abuse 	

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	<p>Meal times were provided on 10/10/14 at 5:00 p.m. Meal times indicated dinner is served to residents in the activity dining room at 5:00 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 indicated during dinner on the night of 10/4/14, Resident #C got upset and started yelling very loud. They had to remove Resident #C from the dining room to get her to calm down. Both Resident #C and Resident #D were present at dinner. They were not at the same table.</p> <p>On 10/9/14 at 10:00 a.m., Unit Manager #3 (UM #3) indicated she had arrived to the facility around 5:30 p.m. She heard of the altercation and that Resident #C was still upset about the room change. She went to talk to Resident #C on the West unit to try and calm her down. When UM #3 left Resident #C she was at the nurses station on the East unit with another nurse. UM #3 then went to talk with Resident #D and her family in the activity room. She was able to get Resident #D's family to agree to move her to a new room. UM #3 then went to tell Resident #C she did not have to move. After she was done talking to Resident #C she was still angry. UM #3 left the nurses station, where Resident #C was with another nurse, to call the DON</p>		<p>Prohibition and Investigation CQI tools weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p>	

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	<p>that Resident #D was moving. UM #3 never got to make the call, because a staff member came to get her due to another altercation between Resident #C and Resident #D had just occurred.</p> <p>Continued review of the facility timeline indicated, UM #3 left Resident #C at 6:32 p.m. to call the DON. The second resident to resident physical altercation occurred at 6:33 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 continued to indicate after dinner she was in the activity room and saw Resident #C coming towards the dining room by herself, as Resident #D's family member was pushing her out of the dining room. As the residents crossed paths Resident #C swung her open hand and hit Resident #D on the arm. Resident #D had a look of shock. Resident #D was confused and did not know what was going on. When staff saw Resident #C enter the dining room and Resident #D leaving they stood up and tried to intervene and make sure they stayed separated, but were unable to make it in time. Once the altercation occurred CNA #4 took Resident #C into the activity room and Resident #D's family took her to her room. CNA #5 indicated she stayed with Resident #C until she left later that evening.</p>						

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	<p>On 10/9/14 at 9:30 a.m., CNA #4 indicated she was in the dining room when she saw Resident #C coming in. She knew Resident #C was not to be near Resident #D, so she got up to get Resident #C. As she was walking over to get her, Resident #D and her family member passed by Resident #C. CNA #4 witnessed Resident #C swing her arm back two times with an open hand. She saw Resident #D get hit once. Resident #D had a surprised look on her face. CNA #4 grabbed Resident #C's wheelchair and tried pushing her away, as she tried pushing her away Resident #C tried digging her feet down making it hard for CNA #4 to push her away. CNA #4 took Resident #C into the activity room to try and calm her down. Resident #C was very angry. Resident #D's family member pushed her away to her room.</p> <p>Resident #D's progress notes dated 10/4/14 at 7:41 p.m., indicated after the altercation, "... skin assessment was done noting 4 small red areas to LLE [left lower extremity] on wrist and lower forearm ..."</p> <p>Continued review of the facility timeline indicated Resident #C's physician was notified at 6:49 p.m., and an order was obtained to send her to the emergency room for evaluation. The Emergency</p>			

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	<p>Medical Technicians arrived at 7:00 p.m.</p> <p>On 10/9/14 at 10:00 a.m., UM #3 continued to indicate she called the physician and obtained an order to send Resident #C to the Emergency Room (ER) for evaluation. When the Emergency Medical Technicians (EMT) arrived Resident #C started yelling and indicated she was not going to the ER. Police then came in and tried to talk with Resident #C. Resident #C continued to yell and attempted to hit and bite the police officers. Resident #C was placed on immediate detention and sent to the ER. UM #3 indicated she thought Resident #C would be out for a few days so she let Resident #D return to her original room. The hospital called a few hours later to inform the facility that the resident would be returning to the facility due to the doctor clearing her. UM #3 called the DON and the DON talked to the hospital case manager about Resident #C. When Resident #C came back from the hospital she was placed on fifteen minute checks.</p> <p>Continued review of the facility timeline indicated at 9:48 p.m. the DON talked to the hospital case manager and was told Resident #C was not a threat to herself or others. DON told the case manager to notify Resident #C that when she</p>						

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	<p>returned to the facility she would be going to a different room. At 10:05 p.m. Resident #C arrived back to the facility.</p> <p>Review of Resident #C's physician order dated 10/4/14 at 10:10 p.m., indicated, "15 minute safety checks." No orders for 15 minute checks nor an order for an intervention to ensure supervision, was found prior to this order.</p> <p>Review of Resident #D's progress notes dated 10/5/14 at 3:39 a.m., 10/6/14 at 4:46 a.m., 10/7/14 at 2:31 p.m., 10/7/14 11:26 p.m., and 10/8/14 at 9:48 p.m. indicated she had four areas of skin alterations to her left arm with no change.</p> <p>Continued review of facility timeline indicated 10/5/14, was a quiet day. On 10/6/14 at 1:00 p.m., Resident #C spoke with the Social Services Director and made threats against Resident #D. At that time Resident #C was placed on one on one observation and Resident #D was moved to a different room on a different unit.</p> <p>On 10/6/14 at 11:05 a.m., the DON provided the Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated October 2013, and indicated the policy was the one currently being used by the facility. The policy</p>			

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F000225 SS=D	<p>indicated, "4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained."</p> <p>This Federal tag relates to Complaint IN00157252.</p> <p>3.1-27(a)(1)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source</p>			

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	<p>and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure the prevention of any further abuse as indicated by facility policy, during the investigation of an allegation of abuse for 1 of 3 residents reviewed for abuse in that after an occurrence of a resident to resident altercation, during the investigation proper interventions were not put into place to prevent another altercation from occurring, which resulted in a skin alteration. (Residents #C and #D) (CNAs #2, #4, and #5) (Unit Manager #3)</p> <p>Findings include:</p>	F000225	<p>Forest Creek Village respectfully requests a face to face IDR for scope and severity of tag F225</p> <p>F225</p> <p>INVESTIGATION/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an</p>	11/03/2014

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	<p>On 10/8/14 at 4:05 p.m., the Director of Nursing (DON) indicated a resident to resident verbal altercation occurred on 10/4/14, between Resident #C and #D. CNA #2 had overheard the argument and came in the shared residents' room to see what was the matter and found the residents arguing over the light in the room. Resident #C alleged Resident #D had poked her in the chest. The DON indicated she came to the residents' room and had someone take Resident #D to the activity room and she stayed with Resident #C to discuss the need to switch rooms for her safety. The DON continued to indicate Resident #C was very upset and refused to switch rooms. Resident #D's family was called to inform them of the altercation and to see if they would be okay with a room switch. Resident #D's family refused. So the DON called the Social Services director and she indicated Resident #C should move for her safety, since she alleged Resident #D poked her. Resident #C's family was called and informed of the altercation and told Resident #C refused to move rooms. Resident #C's family told the DON they would be in to talk to Resident #C and she can move rooms. At this point Resident #C was told she could not go back to her original room.</p>		<p>employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violations is verified appropriate corrective action must be taken.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?—</p>	

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	<p>Review of Resident #C's clinical record on 10/9/14 at 12:00 p.m., indicated the admission MDS (Minimum Data Set) assessment, completed on 9/2/14, assessed Resident #C as having a BIMS (Brief Interview for Mental Status) score of 14, meaning she is cognitively intact. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #D had a "pink/light red" mark in the center of her chest and excoriation under her breast.</p> <p>Review of Resident #D's clinical record on 10/9/14 at 12:15 p.m, indicated diagnoses included, but not limited to, dementia (disorder of mental processes effecting memory, personality, and reasoning) and Alzheimer's Disease (progressive mental deterioration). The quarterly MDS assessment, completed 7/8/14, assessed Resident #D as having a BIMS score of 4, meaning she has severe cognitive impairment. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #C had a skin alteration on her right great toe.</p> <p>On 10/9/14 at 11:10 a.m., the DON indicated after the altercation she told staff the two residents had to remain separated. There was no specific</p>		<p>·Resident C was evaluated by her attendingpsychiatrist for evaluation. He madeadjustments to the plan of care. Resident #C will continue to be followed by psychiatrist for adjustmentsas needed. Social Services or designeewill meet with Resident #C weekly x four weeks to address any behavioralchanges or psychosocial needs.</p> <p>·ResidentD assessed by Social Services weeklyfor two weeks with no indication of distress or recollection of theincident. Social Services will addressany psychosocial needs as needed.</p> <p>·Resident C and D remain in separaterooms</p> <p>·Resident C and D behavior care plansupdated</p> <p>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>·Allresidents who have been involved in resident to resident abuse have thepotential to be affected.</p> <p>·IDTwill complete a review of all residents who have been involved in resident toresident abuse since October 1, 2014 to ensure appropriate measures have beenput in place to ensure resident safety. Any concerns</p>	

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	<p>intervention put in place to ensure they stayed apart, such as fifteen minute checks, one on ones, or designated staff to watch either resident. When the DON left the facility Resident #C was in the activity room and Resident #D was in the residents' room. It had been decided Resident #C was going to move rooms, but they were still waiting on her family to come talk to her.</p> <p>The facility timeline of events that occurred on 10/4/14, was provided by the DON on 10/9/14 at 9:10 a.m. The time line indicated the DON left the facility at 4:30 p.m., Resident #C's family came in to talk with her at 4:30 p.m. and stayed till 5:30 p.m.</p> <p>Meal times were provided on 10/10/14 at 5:00 p.m. Meal times indicated dinner is served to residents in the activity dining room at 5:00 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 indicated during dinner on the night of 10/4/14, Resident #C got upset and started yelling very loud. They had to remove Resident #C from the dining room to get her to calm down. Both Resident #C and Resident #D were present at dinner. They were not at the same table.</p>		<p>with resident safety will be addressed immediately in the plan of care and with the physician.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All nursing staff will be re-educated on the facility's Behavior Management Program and Abuse Prohibition policy; including the need to ensure resident safety after a resident to resident altercation. ·Re-education will be conducted by DNS and completed by 11/3/14. ·The Director of Nursing Services or designee will be contacted immediately after each resident to resident abuse situation. The DNS or designee will work with the staff member to develop an intervention that ensures resident safety. ·All new/worsening behaviors will be reviewed by the interdisciplinary team for a thorough review of the behavior, assessment of potential contributing factors, root cause and implementation of intervention. The interdisciplinary team will review each resident to resident abuse situation and ensure that there are interventions in place to 		

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	<p>On 10/9/14 at 10:00 a.m., Unit Manager #3 (UM #3) indicated she had arrived to the facility around 5:30 p.m. She heard of the altercation and that Resident #C was still upset about the room change. She went to talk to Resident #C on the West unit to try and calm her down. When UM #3 left Resident #C she was at the nurses station on the East unit with another nurse. UM #3 then went to talk with Resident #D and her family in the activity room. She was able to get Resident #D's family to agree to move her to a new room. UM #3 then went to tell Resident #C she did not have to move. After she was done talking to Resident #C she was still angry. UM #3 left the nurses station, where Resident #C was with another nurse, to call the DON that Resident #D was moving. UM #3 never got to make the call, because a staff member came to get her due to another altercation between Resident #C and Resident #D had just occurred.</p> <p>Continued review of the facility timeline indicated, UM #3 left Resident #C at 6:32 p.m. to call the DON. The second resident to resident physical altercation occurred at 6:33 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 continued to indicate after dinner she was in the activity room and saw Resident #C</p>		<p>ensure resident safety.</p> <p>·Corporate consultant will also review all resident to resident abuse incidents weekly times four weeks to ensure interventions for resident safety are maintained.</p> <p>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?</p> <p>·SS/designee will be responsible for the completion of the Resident to Resident Altercations and Abuse Prohibition and Investigation CQI tools weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p>	

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	<p>coming towards the dining room by herself, as Resident #D's family member was pushing her out of the dining room. As the residents crossed paths Resident #C swung her open hand and hit Resident #D on the arm. Resident #D had a look of shock. Resident #D was confused and did not know what was going on. When staff saw Resident #C enter the dining room and Resident #D leaving they stood up and tried to intervene and make sure they stayed separated, but were unable to make it in time. Once the altercation occurred CNA #4 took Resident #C into the activity room and Resident #D's family took her to her room. CNA #5 indicated she stayed with Resident #C until she left later that evening.</p> <p>On 10/9/14 at 9:30 a.m., CNA #4 indicated she was in the dining room when she saw Resident #C coming in. She knew Resident #C was not to be near Resident #D, so she got up to get Resident #C. As she was walking over to get her, Resident #D and her family member passed by Resident #C. CNA #4 witnessed Resident #C swing her arm back two times with an open hand. She saw Resident #D get hit once. Resident #D had a surprised look on her face. CNA #4 grabbed Resident #C's wheelchair and tried pushing her away, as she tried pushing her away Resident #C</p>			

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	<p>tried digging her feet down making it hard for CNA #4 to push her away. CNA #4 took Resident #C into the activity room to try and calm her down. Resident #C was very angry. Resident #D's family member pushed her away to her room.</p> <p>Resident #D's progress notes dated 10/4/14 at 7:41 p.m., indicated after the altercation, "... skin assessment was done noting 4 small red areas to LLE [left lower extremity] on wrist and lower forearm ..."</p> <p>Continued review of the facility timeline indicated Resident #C's physician was notified at 6:49 p.m., and an order was obtained to send her to the emergency room for evaluation. The Emergency Medical Technicians arrived at 7:00 p.m.</p> <p>On 10/9/14 at 10:00 a.m., UM #3 continued to indicate she called the physician and obtained an order to send Resident #C to the Emergency Room (ER) for evaluation. When the Emergency Medical Technicians (EMT) arrived Resident #C started yelling and indicated she was not going to the ER. Police then came in and tried to talk with Resident #C. Resident #C continued to yell and attempted to hit and bite the police officers. Resident #C was placed on immediate detention and sent to the</p>			

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	<p>ER. UM #3 indicated she thought Resident #C would be out for a few days so she let Resident #D return to her original room. The hospital called a few hours later to inform the facility that the resident would be returning to the facility due to the doctor clearing her. UM #3 called the DON and the DON talked to the hospital case manager about Resident #C. When Resident #C came back from the hospital she was placed on fifteen minute checks.</p> <p>Continued review of the facility timeline indicated at 9:48 p.m. the DON talked to the hospital case manager and was told Resident #C was not a threat to herself or others. DON told the case manager to notify Resident #C that when she returned to the facility she would be going to a different room. At 10:05 p.m. Resident #C arrived back to the facility.</p> <p>Review of Resident #C's physician order dated 10/4/14 at 10:10 p.m., indicated, "15 minute safety checks." No orders for 15 minute checks nor an order for an intervention to ensure supervision, was found prior to this order.</p> <p>Review of Resident #D's progress notes dated 10/5/14 at 3:39 a.m., 10/6/14 at 4:46 a.m., 10/7/14 at 2:31 p.m., 10/7/14 11:26 p.m., and 10/8/14 at 9:48 p.m.</p>			

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	<p>indicated she had four areas of skin alterations to her left arm with no change.</p> <p>Continued review of facility timeline indicated 10/5/14, was a quiet day. On 10/6/14 at 1:00 p.m., Resident #C spoke with the Social Services Director and made threats against Resident #D. At that time Resident #C was placed on one on one observation and Resident #D was moved to a different room on a different unit.</p> <p>On 10/6/14 at 11:05 a.m., the DON provided the Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated October 2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained."</p> <p>This Federal tag relates to Complaint IN00157252.</p> <p>3.1-28(d)</p>						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their abuse policy for 1 of 3 residents reviewed for abuse in that after an occurrence of a resident to resident altercation, during the investigation proper interventions were not put into place to prevent another altercation from occurring, which resulted in a skin alteration. (Residents #C and #D) (CNAs #2, #4, and #5) (Unit Manager #3)</p> <p>Findings include:</p> <p>On 10/8/14 at 4:05 p.m., the Director of Nursing (DON) indicated a resident to resident verbal altercation occurred on 10/4/14, between Resident #C and #D. CNA #2 had overheard the argument and came in the shared residents' room to see what was the matter and found the residents arguing over the light in the room. Resident #C alleged Resident #D had poked her in the chest. The DON indicated she came to the residents' room and had someone take Resident #D to the activity room and she stayed with</p>	F000226	<p>Forest Creek Village respectfully requests a face to face IDR for scope and severity of tag F226</p> <p>F 226 DEVELOP/IMPLEMENTABUSE/NEGLECT, ETC POLICIES</p> <p>The facility mustdevelop and implement written policies and procedures that prohibitmistreatment, neglect, and abuse of residents and misappropriation of residentproperty.</p> <p>What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?—</p> <ul style="list-style-type: none"> ·Resident C was evaluated by her attendingpsychiatrist for evaluation. He madeadjustments to the plan of care. Resident #C will continue to be followed by psychiatrist for adjustmentsas needed. Social Services or designeewill meet with Resident #C weekly x four weeks to address any behavioralchanges or psychosocial needs. ·ResidentD assessed by Social Services weeklyfor two weeks with no indication of distress or 	11/03/2014
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	<p>Resident #C to discuss the need to switch rooms for her safety. The DON continued to indicate Resident #C was very upset and refused to switch rooms. Resident #D's family was called to inform them of the altercation and to see if they would be okay with a room switch. Resident #D's family refused. So the DON called the Social Services director and she indicated Resident #C should move for her safety, since she alleged Resident #D poked her. Resident #C's family was called and informed of the altercation and told Resident #C refused to move rooms. Resident #C's family told the DON they would be in to talk to Resident #C and she can move rooms. At this point Resident #C was told she could not go back to her original room.</p> <p>Review of Resident #C's clinical record on 10/9/14 at 12:00 p.m., indicated the admission MDS (Minimum Data Set) assessment, completed on 9/2/14, assessed Resident #C as having a BIMS (Brief Interview for Mental Status) score of 14, meaning she is cognitively intact. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #D had a "pink/light red" mark in the center of her chest and excoriation under her breast.</p>		<p>recollection of the incident. Social Services will address any psychosocial needs as needed.</p> <ul style="list-style-type: none"> ·Resident C and D remain in separate rooms ·Resident C and D behavior care plans updated <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who have been involved in resident to resident abuse have the potential to be affected. ·IDT will complete a review of all residents who have been involved in resident to resident abuse since October 1, 2014 to ensure appropriate measures have been put in place to ensure resident safety. Any concerns with resident safety will be addressed immediately in the plan of care and with the physician. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All nursing staff will be re-educated on the facility's Behavior Management Program and Abuse Prohibition policy; including the need to ensure resident safety after a resident 	

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	<p>Review of Resident #D's clinical record on 10/9/14 at 12:15 p.m, indicated diagnoses included, but not limited to, dementia (disorder of mental processes effecting memory, personality, and reasoning) and Alzheimer's Disease (progressive mental deterioration). The quarterly MDS assessment, completed 7/8/14, assessed Resident #D as having a BIMS score of 4, meaning she has severe cognitive impairment. Skin assessment completed after the first altercation on 10/4/14, from the facility investigation, indicated Resident #C had a skin alteration on her right great toe.</p> <p>On 10/9/14 at 11:10 a.m., the DON indicated after the altercation she told staff the two residents had to remain separated. There was no specific intervention put in place to ensure they stayed apart, such as fifteen minute checks, one on ones, or designated staff to watch either resident. When the DON left the facility Resident #C was in the activity room and Resident #D was in the residents' room. It had been decided Resident #C was going to move rooms, but they were still waiting on her family to come talk to her.</p> <p>The facility timeline of events that occurred on 10/4/14, was provided by the</p>		<p>toresident altercation.</p> <ul style="list-style-type: none"> ·Re-education will be conducted byDNS and completed by 11/3/14. ·The Director of Nursing Services ordesignee will be contacted immediately after each resident to resident abusesituation. The DNS or designee will workwith the staff member to develop an intervention that ensures resident safety. ·All new/worsening behaviors will bereviewed by the interdisciplinary team for a thorough review of the behavior,assessment of potential contributing factors, root cause and implementation ofintervention. The interdisciplinary teamwill review each resident to resident abuse situation and ensure that there areinterventions in place to ensure resident safety. ·Corporate consultant will alsoreview all resident to resident abuse incidents weekly times four weeks toensure interventions for resident safety are maintained. <p>How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality</p>	

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	<p>DON on 10/9/14 at 9:10 a.m. The time line indicated the DON left the facility at 4:30 p.m., Resident #C's family came in to talk with her at 4:30 p.m. and stayed till 5:30 p.m.</p> <p>Meal times were provided on 10/10/14 at 5:00 p.m. Meal times indicated dinner is served to residents in the activity dining room at 5:00 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 indicated during dinner on the night of 10/4/14, Resident #C got upset and started yelling very loud. They had to remove Resident #C from the dining room to get her to calm down. Both Resident #C and Resident #D were present at dinner. They were not at the same table.</p> <p>On 10/9/14 at 10:00 a.m., Unit Manager #3 (UM #3) indicated she had arrived to the facility around 5:30 p.m. She heard of the altercation and that Resident #C was still upset about the room change. She went to talk to Resident #C on the West unit to try and calm her down. When UM #3 left Resident #C she was at the nurses station on the East unit with another nurse. UM #3 then went to talk with Resident #D and her family in the activity room. She was able to get Resident #D's family to agree to move</p>		<p>assurance program will be put into place?</p> <p>·SS/designee will be responsible for the completion of the Resident to Resident Altercations and Abuse Prohibition and Investigation CQI tools weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p>	

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	<p>her to a new room. UM #3 then went to tell Resident #C she did not have to move. After she was done talking to Resident #C she was still angry. UM #3 left the nurses station, where Resident #C was with another nurse, to call the DON that Resident #D was moving. UM #3 never got to make the call, because a staff member came to get her due to another altercation between Resident #C and Resident #D had just occurred.</p> <p>Continued review of the facility timeline indicated, UM #3 left Resident #C at 6:32 p.m. to call the DON. The second resident to resident physical altercation occurred at 6:33 p.m.</p> <p>On 10/9/14 at 11:25 a.m., CNA #5 continued to indicate after dinner she was in the activity room and saw Resident #C coming towards the dining room by herself, as Resident #D's family member was pushing her out of the dining room. As the residents crossed paths Resident #C swung her open hand and hit Resident #D on the arm. Resident #D had a look of shock. Resident #D was confused and did not know what was going on. When staff saw Resident #C enter the dining room and Resident #D leaving they stood up and tried to intervene and make sure they stayed separated, but were unable to make it in time. Once the altercation</p>			

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	<p>occurred CNA #4 took Resident #C into the activity room and Resident #D's family took her to her room. CNA #5 indicated she stayed with Resident #C until she left later that evening.</p> <p>On 10/9/14 at 9:30 a.m., CNA #4 indicated she was in the dining room when she saw Resident #C coming in. She knew Resident #C was not to be near Resident #D, so she got up to get Resident #C. As she was walking over to get her, Resident #D and her family member passed by Resident #C. CNA #4 witnessed Resident #C swing her arm back two times with an open hand. She saw Resident #D get hit once. Resident #D had a surprised look on her face. CNA #4 grabbed Resident #C's wheelchair and tried pushing her away, as she tried pushing her away Resident #C tried digging her feet down making it hard for CNA #4 to push her away. CNA #4 took Resident #C into the activity room to try and calm her down. Resident #C was very angry. Resident #D's family member pushed her away to her room.</p> <p>Resident #D's progress notes dated 10/4/14 at 7:41 p.m., indicated after the altercation, "... skin assessment was done noting 4 small red areas to LLE [left lower extremity] on wrist and lower forearm ..."</p>				

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	<p>Continued review of the facility timeline indicated Resident #C's physician was notified at 6:49 p.m., and an order was obtained to send her to the emergency room for evaluation. The Emergency Medical Technicians arrived at 7:00 p.m.</p> <p>On 10/9/14 at 10:00 a.m., UM #3 continued to indicate she called the physician and obtained an order to send Resident #C to the Emergency Room (ER) for evaluation. When the Emergency Medical Technicians (EMT) arrived Resident #C started yelling and indicated she was not going to the ER. Police then came in and tried to talk with Resident #C. Resident #C continued to yell and attempted to hit and bite the police officers. Resident #C was placed on immediate detention and sent to the ER. UM #3 indicated she thought Resident #C would be out for a few days so she let Resident #D return to her original room. The hospital called a few hours later to inform the facility that the resident would be returning to the facility due to the doctor clearing her. UM #3 called the DON and the DON talked to the hospital case manager about Resident #C. When Resident #C came back from the hospital she was placed on fifteen minute checks.</p>			

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	<p>Continued review of the facility timeline indicated at 9:48 p.m. the DON talked to the hospital case manager and was told Resident #C was not a threat to herself or others. DON told the case manager to notify Resident #C that when she returned to the facility she would be going to a different room. At 10:05 p.m. Resident #C arrived back to the facility.</p> <p>Review of Resident #C's physician order dated 10/4/14 at 10:10 p.m., indicated, "15 minute safety checks." No orders for 15 minute checks nor an order for an intervention to ensure supervision, was found prior to this order.</p> <p>Review of Resident #D's progress notes dated 10/5/14 at 3:39 a.m., 10/6/14 at 4:46 a.m., 10/7/14 at 2:31 p.m., 10/7/14 11:26 p.m., and 10/8/14 at 9:48 p.m. indicated she had four areas of skin alterations to her left arm with no change.</p> <p>Continued review of facility timeline indicated 10/5/14, was a quiet day. On 10/6/14 at 1:00 p.m., Resident #C spoke with the Social Services Director and made threats against Resident #D. At that time Resident #C was placed on one on one observation and Resident #D was moved to a different room on a different unit.</p>			

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F000371 SS=E	<p>On 10/6/14 at 11:05 a.m., the DON provided the Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated October 2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained."</p> <p>This Federal tag relates to Complaint IN00157252.</p> <p>3.1-28(a)</p> <p>483.35(i) 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 Based on observation, interview, and record review, the facility failed to ensure 114 of 115 residents, who ate food prepared in the kitchen, received food prepared, distributed and served under sanitary conditions.</p>	F000371	F371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	11/03/2014

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	<p>Findings include:</p> <p>1. On 10/6/14 from 12:30 p.m. to 12:45 p.m., food service was observed in the Moving Forward dining room. Dietary Cook #1 was observed preparing each resident's plate from a steam table cart. She washed her hands and donned gloves. Dietary Cook #1 started preparing plates. She opened the bread bag, removed two slices of bread with her gloved hands and placed the bread on a plate. Dietary Cook #1 continued by picking up a scoop with her gloved hand and placed a serving of turkey salad on one slice of bread. She then picked up the other slice of bread with her gloved hand and placed the bread on top of the turkey salad.</p> <p>Dietary Cook #1 then picked up the cheese puff scoop with the her gloved hand and placed cheese puffs on the plate next to the turkey salad sandwich. She continued to pick up a bowl and the soup scoop and pour soup into the bowl. She placed these plates on the tray in front of her.</p> <p>Dietary Cook #1 then shuffled through the dining slips of paper with the same gloved hands.</p>		<p>·All residents will be served according to proper food handling procedures including hand washing and glove use</p> <p>·All dietary employees will have hair properly restrained</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice</p> <p>·Dietary staff will be in-serviced on Infection Control, Use of Gloves, Hand Washing, Dietary Personal Hygiene and Food Handling policies by the Registered Dietician or designee by 11/03/2014</p> <p>·Registered Dietitian or designee will monitor kitchen processes to ensure proper hand washing, glove use, hair restraints, and food handling follows protocol</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Dietary staff will be in-serviced on Infection Control, Use of Gloves, Hand Washing, Dietary</p>		

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	<p>Dietary Cook #1 then picked up two more slices of bread and placed them on another plate with the same gloved hands. She continued by picking up the turkey scoop and placed a scoop of turkey salad on one of the slices of bread. She used the same gloved hand and moved the turkey salad around on the piece of bread. She then picked up the other slice of bread with her same gloved hand and put it on top of the scoop of turkey salad.</p> <p>Dietary Cook #1 continued preparing plates of food for the residents with the same gloved hands. She was not observed to use any form of utensil to serve the bread through the observation period. Dietary Cook #1 was not observed to remove the original set of gloves and wash her hands, until after 11 (9 residents and 2 family members) plates of food were prepared and served.</p> <p>On 10/6/14 at 1:00 p.m., the Dietary Manager indicated Dietary Cook #1 should have used a different utensil for each food item she was serving, this includes using tongs to handle the bread slices. The dietary cook should not have used her gloved hands to pick up the bread slices.</p> <p>On 10/9/14 at 2:30 p.m., the Dietary</p>		<p>Personal Hygiene and Food Handling policies by the Registered Dietician or designee by 11/03/2014</p> <ul style="list-style-type: none"> ·Registered Dietitian or designee will monitor kitchen processes during each meal to ensure proper hand washing, glove use, hair restraints, and food handling follows protocol using audit tool <p>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?</p> <ul style="list-style-type: none"> ·A Kitchen Sanitation/Environmental Review tool will be utilized weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·In addition, a full sanitation audit will be conducted by RD Consultant monthly ·If 95% threshold is not achieved on the Sanitation/Environmental Review tool, an action plan will be developed to ensure compliance 	

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	<p>Manager provided the Use of Gloves policy, dated 04/2011, and indicated the policy was the one currently being used by the facility. The policy indicated, "... 3. Gloves are just like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed and hands washed...."</p> <p>On 10/9/14 at 2:30 p.m., the Dietary Manager provided the Food Handling Policy, dated 01/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "... 1. Food employees ... will clean their hands and exposed portions of their arms: ... d) after handing soiled surfaces, equipment or utensils;"</p> <p>2. During the service of noon meal on 10/10/14 at 11:00 a.m., the following were observed:</p> <p>A. Dietary Aide #10 was observed to have facial hair, a beard and mustache, uncovered while preparing and serving the noon meal.</p> <p>B. Dietary Cook #1 was observed to prepare and serve the noon meal with her hair net covering only the back half of her hair, exposing the front half of her hair.</p> <p>On 10/10/14 at 1:30 p.m., review of</p>			

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	<p>policy provided by dietary manager as facility's current policy: American Senior Communities Dietary Personal Hygiene, original date of 02/07. "Policy: Employees will maintain good personal hygiene to prevent food contamination...Under procedure #3 a. Wear a clean hat and/or other hair restraint. Dietary employees with facial hair should also wear a beard restraint...."</p> <p>During an interview with the Dietary Manager on 10/10/14 at 1:30 p.m., she indicated the staff receive training and policies are gone over during orientation, and staff receive miniseries and protocol updates through the duration of their employment. She indicated she expects the hair cover to effectively cover head and/or facial hair (moustache and/or beard) and be worn in the food preparation areas to prevent contamination of food equipment and utensils.</p> <p>This Federal tag relates to Complaints IN00157252 and IN00157308.</p> <p>3.1-21(i)(3)</p>			