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| 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 05/22/2013 |
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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 Complaint IN00127938.</p> <p>Complaint IN00127938-Substantiated. Federal/state deficiencies related to the allegation(s) are cited at F170.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date(s): May 21 & 22, 2013</p> <p>Facility number: 000145 Provider number: 155241 AIM number: 100275110</p> <p>Survey team: Lora Brettnacher, RN-TC Jeanna King, RN</p> <p>Census bed type: SNF: 13 NF: 98 Total: 111</p> <p>Census payor type: Medicare: 16 Medicaid: 75 Other: 20 Total: 111</p> <p>Sample 5</p> | F000000 | The facility would like to request paper compliance with the submitted plan of correction. | |

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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 28, 2013; by Kimberly Perigo, RN.</p> | | | | |

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| F000170 SS=D | <p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>Based on interview and record review, the facility failed to ensure residents received mail unopened for 1 of 3 residents reviewed in a sample of 5 (Resident #B).</p> <p>Resident #B's record was reviewed on 5/21/2013 at 1:00 P.M. Resident #B had diagnoses which included, but were not limited to, history of respiratory failure with current tracheotomy, dysphagia, insomnia, depression, paranoid delusions, and squeamish cell carcinoma of the right mandible, cheek, and skull base.</p> <p>A re-entry Minimum Data Set Assessment Tool (MDS) dated 4/13/2013, indicated, Resident #B was alert and oriented, with his cognition intact with the highest score possible of 15, had no behaviors, delusions, rejection of care, or taking anti-psychotic medication. Behavior monitoring records dated April 2013 and May 2013 indicated, Resident #B exhibited no aggression or delusional behavior.</p> | F000170 | <p>F 170</p> <p>1. Resident B receives mail unopened.</p> <p>2. All residents have the potential to be affected.</p> <p>All staff were in-serviced regarding resident rights, mail delivery and delivering mail unopened to the residents by the Staff Development Coordinator by 6-11-13.</p> <p>3. All staff were in-serviced regarding resident rights, mail delivery preferences, and delivering mail unopened to the residents by the Staff Development Coordinator by 6-11-13.</p> <p>Resident preferences regarding mail delivery will be obtained on admission by activity staff. Mail will be delivered unopened unless the resident or responsible party requests forwarding or assistance with opening/reading mail. Care plan will indicate special requests for mail delivery.</p> <p>4. To ensure compliance, the Director of Nursing Services /</p> | 06/21/2013 | | | |

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| | <p>During an observation on 5/21/2013 at 10:30 A.M., Resident B was observed sitting in his room. Resident #B had a tracheotomy and was unable to verbally express himself. He had a white board he used to communicate. He also had a cell phone he used to text to communicate.</p> <p>During an interview on 5/21/2013 at 10:30 A.M., Resident #B indicated his mail had been opened at least weekly for months without his permission. He indicated as recently as this month. He did not have a trusting relationship with the Executive Director (ED) or Social Service Staff (SS) #1. He indicated he felt anything he reported to them fell on deaf ears. He indicated he has never given anyone permission to open his mail. He indicated he as requested SS #1 not to deliver his mail.</p> <p>During an interview on 5/21/2013 at 12:30 P.M., SS #1 stated, "He doesn't care for me. Automatically he was anti-me. He thinks I am opening his mail.... He doesn't tell me his grievances." SS #1 indicated she has not delivered Resident #B's mail. She stated, "All his mail goes straight to Activities and they deliver it straight to him unopened the day it arrives."</p> | | <p>Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly 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 to ensure compliance.</p> | | | | |

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| | <p>During an interview on 5/21/2013 at 11:00 A.M., Confidential Interviewee #2 stated, "They do open his mail. He his is own POA (Power of Attorney). The SS #1 opened his mail and retaped it. It also sat in her office for a long time before being delivered to him. The business office also opened his mail. At least twice a week it was opened before I could deliver it to him." She indicated the mail has been opened within the last six months. She indicated their excuse was to check for sharp objects however, there were only two residents whose mail they opened without their permission and Resident #B was one of them. Confidential Interviewee #2 stated, "He asked for his mail not to be opened. We brought this to everybody's attention during morning meetings."</p> <p>During an interview on 5/22/2013 at 10:30 A.M., Confidential Interviewee #3 indicated, Resident #B's mail had been opened prior to it being delivered to him.</p> <p>During an interview on 5/22/2013 at 10:35 A.M., Activity Staff #4, indicated, Resident #B's mail was to be delivered by activity staff only. She further indicated Resident #B did</p> | | | |

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| | <p>not trust certain people.</p> <p>A social service noted created by SS #1 on 4/18/2013 at 9:53 A.M., indicated, "Res [resident] continues to make delusional false accusations making statements such as staff is keeping and opening mail. Res has been reassured several times that mail is not being opened and that every time SS has delivered a package it has been sealed. Res continues to threaten to call post office and report SS to federal authorities [sic]."</p> <p>A progress note created by SS #1, dated 4/8/2013 at 12:20 P.M., indicated, "Res [resident] received a package today. SS went to deliver package to res, SS knocked on the door and res answered, SS greeted re [sic] and handed him his package. Res appeared to be angry. Res took the package and then shook his finger, in a scolding manner, at writer. SS asked res to repeat and he wrote on his whit board, 'I want you to leave my stuff alone.' SS stated, 'I was just delivering your package.' Then res slammed the door shut. The package was sealed when delivered to res."</p> <p>During an interview on 5/21/2013 at 1:20 A.M., the Ombudsman indicated,</p> | | | |

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| | <p>Resident #B had a mistrust of the ED and SS #1, because of the mail and other on going issues.</p> <p>The facility's undated policy regarding resident mail was provided by the ED on 5/22/2013 at 8:56 A.M. The policy indicated, "Policy: The activity department will facilitate the delivery of resident mail. Staff will respect the resident's right to privacy in written communication. Procedure: Resident preferences regarding mail delivery will be obtained on admission. Mail will be delivered unopened unless the resident or responsible party request forwarding or assistance with opening/reading mail. Mail will be delivered to the resident within 24 hours of being received by the postal service. Mail will be delivered six days weekly, excluding holidays...."</p> <p>This Federal tag relates to Complaint IN00127938.</p> <p>3.1-3(s)(1)</p> | | | |

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| F000225 SS=D | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/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 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 violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p> | F000225 | | | | 06/21/2013 | |

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| | <p>interview, the facility failed to report an allegation of abuse to the State Department of Health for 2 of 2 residents reviewed for abuse protocols in a sample of 5 (Resident #C & Resident #D).</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 5/21/2013 at 2:23 P.M. Resident #C had diagnoses which included, but were not limited to, schizophrenic disorder and anxiety.</p> <p>During an interview on 5/21/2013 at 2:16 P.M., Resident #C's daughter indicated, she reported to a social worker in March that her mother was upset because a Certified Nursing Assistant (CNA) had been rude and stern with her. She indicated she had the Social Worker come talk directly to her mom so she could hear it straight from her mom.</p> <p>Review of a document titled, "Resident/Family concern/Grievance Form" dated 3/11/2013 and signed by Social Service Staff #2 indicated, on 3/11/2013, "Resident's daughter stopped me to talk with [Resident #C named] reporting that CNA [CNA #50 named] was stern with her telling her she had to get up on on her own on</p> | | <p>F 225</p> <p>1. Incident involving Resident C has been investigated and reported to ISDH per facility policy. Resident D no longer resides in this facility.</p> <p>2. All residents have the potential to be affected. All staff was provided education by the Staff Development Coordinator or designee regarding requirements to report allegations of abuse to ISDH in a timely manner by 6-21-13. All grievances received within the last month were reviewed to ensure all were handled appropriately following grievance and reporting allegations of abuse policies.</p> <p>3. All staff was provided education by the Staff Development Coordinator or designee regarding requirements to report allegations of abuse to ISDH in a timely manner on by 6-21-13. Executive Director will report all allegations of abuse per facility policy and procedures and federal and state regulations and give a monthly report of all allegations to the Director of Operations.</p> <p>4. To ensure compliance, the Director of Nursing Services/ Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool weekly</p> | | | | |

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| | <p>her own-[Resident #C named] upset with the tone and felt CNA #50 was rude to her-[Resident can be quite demanding]."</p> <p>During an interview on 5/21/2013 at 2:10 P.M., SS #2 indicated, Resident #C was fairly alert and she reported the allegation of abuse immediately to the former Director of Nursing.</p> <p>During an interview on 5/21/2013 at 12:15 P.M., the Executive Director (ED) indicated he reported all allegations of abuse to the State Department of Health.</p> <p>During an interview on 5/21/2013 at 2:00 P.M., The ED was asked to provide documentation the allegation of abuse Resident #C reported to SS #2 was reported to the State Department of Health as indicated by the facility's abuse prohibition policy and procedures and as indicated by regulatory requirements.</p> <p>During an interview on 5/22/2013 at 10:50 A.M., the ED indicated, the allegation(s) of abuse to Resident #C were not reported.</p> <p>2. Resident #D's record was reviewed on 5/22/2013 at 9:00 A.M..</p> | | <p>times 4 weeks, bi-monthly times 2 months, and then quarterly 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 100% is not achieved an action plan will be developed to ensure compliance.</p> | |

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| | <p>Resident #D had diagnoses which included, but were not limited to, anxiety and hypertension.</p> <p>Review of a document titled, "Resident/Family concern/Grievance Form" dated 1/27/2013, indicated, Resident #D reported a concern that happened the day before on 1/26/2013. She stated, "When the short dark-haired girl white girl was helping me in the bathroom she was rough with me. Res (resident) questioned further and also stated I don't know why she had to stick her finger in that hole. This writer asked res if she was referring to her rectum and she replied I guess."</p> <p>During an interview on 5/21/2013 at 2:00 P.M., The ED was asked to provide documentation the allegations of abuse to Resident #D were reported to the State Department of Health as indicated by the facility's abuse prohibition policy and procedures and as indicated by regulatory requirements.</p> <p>During an interview on 5/22/2013 at 10:50 A.M., the ED indicated, the allegation(s) of abuse to Resident #D were not reported.</p> <p>The facility's abuse prohibition policy</p> | | | |

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| | <p>dated 2010/revised 2012, was provided by the ED on 5/21/2013 at 10:45 P.M. The policy indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse....Physical abuse-includes hitting, slapping, pinching, and kicking....Verbal Abuse-...Examples would include, but are not limited to:...or scolding and/or speaking to them in harsh voice tones....Sexual Abuse...sexual assault....The Executive Director or the Director of Nursing is responsible for unifying the following agencies, as outlined in the "Unusual occurrence reporting guidelines". Indiana State Department of Health...."</p> <p>3.1-28(c)</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 record review and interview, the facility failed to implement their abuse prohibition policy for 2 of 2 residents reviewed for grievances regarding alleged abuse in sample of 5 (Resident #C & Resident #D).</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 5/21/2013 at 2:23 P.M. Resident #C had diagnoses which included, but were not limited to, schizophrenic disorder and anxiety.</p> <p>During an interview on 5/21/2013 at 2:16 P.M., Resident #C's daughter indicated, she reported to a social worker in March that her mother was upset because a Certified Nursing Assistant (CNA) had been rude and stern with her. She indicated she had the Social Worker come talk directly to her mom so she could hear it straight from her mom.</p> <p>Review of a document titled,</p> | F000226 | <p>F 226</p> <p>Incident involving Resident C have been investigated and reported to ISDH per facility policy. Resident D no longer resides at this facility.</p> <p>2. All residents have the potential to be affected. All management staff was re-educated by Nurse Consultant regarding requirements to report allegations of abuse to ISDH in a timely manner on 6-21-13. All grievances received within the last month were reviewed to ensure all were handled appropriately following grievance and reporting allegations of abuse policies.</p> <p>3. All management staff was provided education by Nurse Consultant regarding requirements to report allegations of abuse to ISDH in a timely manner on 6-21-13 .Executive Director will report all allegations of abuse per facility policy and procedures and federal and state regulations and give a monthly report of all allegations to the Director of Operations.</p> | 06/21/2013 | |

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| | <p>"Resident/Family concern/Grievance Form" dated 3/11/2013 and signed by Social Service Staff #2 indicated, on 3/11/2013, "Resident's daughter stopped me to talk with [Resident #C named] reporting that CNA [CNA #50 named] was stern with her telling her she had to get up on on her own on her own-[Resident #C named] upset with the tone and felt CNA #50 was rude to her-[Resident can be quite demanding]."</p> <p>During an interview on 5/21/2013 at 2:10 P.M., SS #2 indicated, Resident #C was fairly alert and she reported the allegation of abuse immediately to the former Director of Nursing.</p> <p>During an interview on 5/21/2013 at 12:15 P.M., the Executive Director (ED) indicated he reported all allegations of abuse to the State Department of Health.</p> <p>During an interview on 5/21/2013 at 2:00 P.M., The ED was asked to provide documentation the allegation of abuse Resident #C reported to SS #2 was reported to the State Department of Health as indicated by the facility's abuse prohibition policy and procedures and as indicated by regulatory requirements</p> | | <p>4. To ensure compliance, the Director of Nursing Services/ Designee is responsible for the completion of the Abuse Prohibition and Investigation CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly 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 100% is not achieved an action plan will be developed to ensure compliance.</p> | |

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| | <p>During an interview on 5/22/2013 at 10:50 A.M., the ED indicated, the allegation(s) of abuse to Resident #C were not reported.</p> <p>2. Resident #D's record was reviewed on 5/22/2013 at 9:00 A.M.. Resident #D had diagnoses which included, but were not limited to, anxiety and hypertension.</p> <p>Review of a document titled, "Resident/Family concern/Grievance Form" dated 1/27/2013, indicated, Resident #D reported a concern that happened the day before on 1/26/2013. She stated, "When the short dark-haired girl white girl was helping me in the bathroom she was rough with me. Res [resident] questioned further and also stated I don't know why she had to stick her finger in that hole. This writer asked res if she was referring to her rectum and she replied I guess."</p> <p>During an interview on 5/21/2013 at 2:00 P.M., The ED was asked to provide documentation the allegation of abuse to Resident #D were reported to the State Department of Health as indicated by the facility's abuse prohibition policy and procedures and as indicated by regulatory requirements.</p> | | | |

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| | <p>During an interview on 5/22/2013 at 10:50 A.M., the ED indicated, the allegation(s) of abuse to Resident #D were not reported.</p> <p>The facility's abuse prohibition policy dated 2010/revised 2012, was provided by the ED on 5/21/2013 at 10:45 P.M. The policy indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse....Physical abuse-includes hitting, slapping, pinching, and kicking....Verbal Abuse-...Examples would include, but are not limited to:...or scolding and/or speaking to them in harsh voice tones....Sexual Abuse...sexual assault....The Executive Director or the Director of Nursing is responsible for notifying the following agencies, as outlined in the "Unusual occurrence reporting guidelines". Indiana State Department of Health...."</p> <p>3.1-28(a)</p> | | | |

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| F000242 SS=D | <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were provided self-determination to make choices with whom they interact with inside the facility and make choices regarding aspects of his/her life for 1 of 3 residents reviewed for choices in a total sample of 5 (Resident #B).</p> <p>Resident #B's record was reviewed on 5/21/2013 at 1:00 P.M. Resident #B had diagnoses which included, but were not limited to, history of respiratory failure with current tracheotomy, dysphagia, insomnia, depression, paranoid delusions, and squeamish cell carcinoma of the right mandible, cheek, and skull base.</p> <p>A re-entry Minimum Data Set Assessment Tool (MDS) dated 4/13/2013, indicated, Resident #B was alert and oriented, with his cognition intact with the highest score possible of 15, had no behaviors,</p> | F000242 | F 242 1. Resident B receives mail unopened. SS #1 does not come into resident B room and care plan has been updated. All residents in facility can choose with whom they interact or do not. All residents will also be allowed to make choices in regards to their daily lives provided these choices do not adversely affect their safety at the facility. 2. All residents have the potential to be affected. All staff were in-serviced regarding mail delivery and delivering mail unopened to the residents by Staff Development Coordinator/Designee by 6-11-13. All staff in-serviced on residents rights and freedom to make choices including with whom they interact or do not by the Staff Development Coordinator/Designee before 7-5-13. 3. All staff were in-serviced regarding mail delivery preferences, and delivering mail unopened to the residents by Staff Development Coordinator/Designee by 6-11-13. All staff were in-serviced on resident rights and freedom to | 06/21/2013 | | | |

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| | <p>delusions, rejection of care, or taking anti-psychotic medication. Behavior monitoring records dated April 2013 and May 2013 indicated, Resident #B exhibited no aggression or delusional behavior.</p> <p>During an observation on 5/21/2013 at 10:30 A.M., Resident #B was observed sitting in his room. Resident #B had a tracheotomy and was unable to verbally express himself. He had a white board he used to communicate. He also had a cell phone he used to text to communicate.</p> <p>During an interview on 5/21/2013 at 10:30 A.M., Resident #B indicated his mail had been opened at least weekly for months without his permission. He indicated as recently as this month. He did not have a trusting relationship with the Executive Director or Social Service Staff (SS) #1. He indicated he felt anything he reported to them fell on deaf ears. He indicated he has never given anyone permission to open his mail. He indicated he had requested Social Worker #1 not to deliver his mail or come into his room. During this interview, an observation was made of SS #1. She knocked on Resident #B's door, entered the room, and</p> | | <p>make choices including with whom they do or do not interact with by the Staff Development Coordinator/Designee before 7-5-13. Resident preferences regarding mail delivery will be obtained on admission by activity staff. Mail will be delivered unopened unless the resident or responsible party requests forwarding or assistance with opening/reading mail. Care plan will indicate special requests for mail delivery. Executive Director/Designee will interview resident B weekly to ensure resident is able to choose who resident wishes to interact with during provision of care and staff who are not to be in room do not enter room. Resident will be interviewed to ensure resident is able to make choices regarding his daily routine, and schedule.4. To ensure compliance, the Director of Nursing Services / Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly 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 to ensure compliance.</p> | | |

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| | <p>stated, "[Resident #B's name]." At that time, Resident #B wrote on his white board, "I do not want her in here."</p> <p>During an interview on 5/21/2013 at 12:30 P.M., SS #1 stated, "He doesn't care for me. Automatically he was anti-me. He thinks I am opening his mail.... He doesn't tell me his grievances." She further indicated, for the last 3 months all of Resident #B's grievances go strictly through his Ombudsman. The Ombudsman communicated his concerns to us because Resident #B did not want to deal with me or the ED (Executive Director). SS #1 indicated she has not delivered Resident #B's mail. She stated, "All his mail goes straight to Activities and they deliver it straight to him unopened the day it arrives."</p> <p>During an interview on 5/22/2013 at 10:35 A.M., Activity Staff #4, indicated, Resident #B's mail was to be delivered by activity staff only. She further indicated Resident #B did not trust certain people.</p> <p>A social service noted created by SS #1 on 4/18/2013 at 9:53 A.M., indicated, "Res [resident] continues to make delusional false accusations making statements such as staff is</p> | | | |

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| | <p>keeping and opening mail. Res has been reassured several times that mail is not being opened and that every time SS has delivered a package it has been sealed. Res continues to threaten to call post office and report SS to federal authorities.[sic]"</p> <p>A progress note created by SS #1, dated 4/8/2013 at 12:20 P.M., indicated, "Res [resident] received a package today. SS went to deliver package to res, SS knocked on the door and res answered, SS greeted res and handed him his package. Res appeared to be angry. Res took the package and then shook his finger, in a scolding manner, at writer. SS asked res to repeat and he wrote on his white board, 'I want you to leave my stuff alone.' SS stated, 'I was just delivering your package.' Then res slammed the door shut. The package was sealed when delivered to res."</p> <p>During an interview on 5/21/2013 at 1:20 A.M., the Ombudsman indicated, Resident #B had a mistrust of the ED and SS #1, because of the mail and other on going issues.</p> <p>The facility's undated policy regarding resident mail was provided by the ED</p> | | | |

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| | <p>on 5/22/2013 at 8:56 A.M. The policy indicated, "Policy: The activity department will facilitate the delivery of resident mail...."</p> <p>During an interview on 5/22/2013 at 10:00 A.M., with the ED and SS #1, the ED indicated the facility employed three social workers. SS #1 was asked why she entered Resident B's room and continued to deliver his mail when she was aware of his request and distrust of her. She indicated she had to do her job and the Resident #B did not trust anyone. She further indicated, she did not understand if Resident #B was so unhappy living at the facility he should move elsewhere.</p> <p>3.1-3(u)(2) 3.1-3(u)(3)</p> | | | |

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| F000254 SS=D | <p>483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. Based on observation, interview, and record review, the facility failed to provide a resident with clean wash clothes for 1 of 1 residents reviewed for adequate linens in a sample of 5 (Resident #B).</p> <p>Resident #B's record was reviewed on 5/21/2013 at 1:00 P.M. Resident #B had diagnoses which included, but were not limited to, history of respiratory failure with current tracheotomy, dysphagia, insomnia, depression, paranoid delusions, and squeamish cell carcinoma of the right mandible, cheek, and skull base.</p> <p>A re-entry Minimum Data Set Assessment Tool (MDS) dated 4/13/2013, indicated, Resident #B was alert and oriented, with his cognition intact with the highest score possible of 15, had no behaviors, delusions, rejection of care, or taking anti-psychotic medication. Behavior monitoring records dated 4/13 and 5/13 indicated, Resident #B exhibited no aggression or delusional behavior.</p> <p>During an observation on 5/21/2013 at 10:30 A.M., Resident #B was</p> | F000254 | <p>F 254</p> <p>1. Resident B has been provided at least 7 wash clothes daily to ensure resident wash cloth needs are met.</p> <p>2. All residents have the potential to be affected. All staff have been in-serviced by the Staff Development Coordinator by 6-11-13 regarding the provision of wash clothes and ensuring an adequate amount of wash clothes are available for all residents. Laundry supervisor checked all linen closets to ensure adequate amount of wash clothes were available.</p> <p>3. All staff have been in-serviced by the Staff Development Coordinator by 6-11-13 regarding the provision of wash clothes and ensuring an adequate amount of wash clothes are available for all residents.</p> <p>Laundry staff supervisor/designee will inventory wash clothes each morning to ensure adequate amount of wash clothes are available in the linen closets.</p> <p>4. To ensure compliance, the Director of Nursing Services/ Designee is responsible for the</p> | 06/21/2013 | |

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| | <p>observed sitting in his room. Resident #B had a tracheotomy and was unable to verbally express himself. He had a white board he used to communicate. His tracheotomy was observed oozing yellow sputum. He was observed wiping his tracheotomy secretions with a wash clothe. A pink basin sitting on the floor was full of dirty wash clothes. No clean clothes were observed in the room.</p> <p>During an interview on 5/21/2013 at 10:30 A.M., Resident #B indicated the facility would not provide him with enough clean wash clothes. He further indicated he needed at least seven daily.</p> <p>During an interview on 5/21/2013 at 12:30 P.M., the ED (Executive Director) indicated, Resident #B had a problem with hoarding linens so they came up with a plan to put his name on 12 wash clothes. When those were dirty they would be washed and returned to him. He further indicated, Resident #B refused to let anyone clean his room.</p> <p>During an observation on 5/22/2013 at 9:15 A.M., the pink basin in Resident #B's room was overflowing with washcloths. Resident #B was</p> | | <p>completion of the Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly 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 to ensure compliance.</p> | |

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| | <p>asked if he refused to let staff remove and replace the dirty wash clothes. He stated, "no."</p> <p>During a confidential interview on 5/22/2013 at 9:20 A.M., Staff #20 indicated, it was the CNAs responsibility to remove the dirty linen and they just have not got around to it today. Staff #20 was asked if Resident #B refused to allow staff to remove the dirty wash clothes, Staff #20 indicated, no. Staff #20 further indicated they did not think they were marking his wash clothes anymore. Staff #20 was asked to count the number of dirty wash clothes in the basin. Staff #20 counted 15 dirty wash clothes and 1 dirty towel.</p> <p>During an interview on 5/22/2013 at 10:00 A.M., SS #1 indicated, Resident #B used the wash clothes for wiping his tracheotomy, wiping his white board, blowing his nose, and personal care. Laundry removed the dirty wash clothes daily and replaced them with clean wash clothes. At that time, the ED and SS #1 were informed of the observations of the pink basin overflowing with dirty washcloths and Resident #B not having any clean washcloths. At that time, documentation of Resident #B refusing to have dirty wash clothes</p> | | | |

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| | <p>removed from his room and replaced with clean wash clothes was requested.</p> <p>During an interview on 5/22/2013 at 10:50 A.M., the ED indicated he did not have documentation of Resident #B specifically refusing to have the dirty wash clothes removed from the room. He further indicated he believed Resident #B left them in the room on purpose because he knew the State was in the building. He indicated Resident #B could walk to the clean linen and get his own wash clothes.</p> <p>3.1-19(g)(5)</p> | | | |