STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAKS HEALTH CAMPUS	2011 CHAPA DR COLUMBUS, IN 47203

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F0000	This visit was for the Investigation of Complaint IN00120307. Complaint IN00120307 Substantiated - Federal/state deficiencies related to allegations are cited at F309. Unrelated deficiencies are cited. Survey dates: December 5 and 6, 2012 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 47 SNF: 26 Residential: 33 Total: 106 Census payor type: Medicare: 24 Medicaid: 19 Other: 63 Total: 106 Sample: 7 These deficiencies reflect state findings	F0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey on December 6, 2012. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2. Quality review completed 12/10/12 Cathy Emswiller RN			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with excoriation of the upper thighs and a wound to the mid-back received treatments as ordered for 1 of 5 residents observed during skin care in a sample of 7. (Resident A) Findings include: On 12/5/12 at 1:45 p.m., LPN #5 and CNA #12 were observed assisting Resident A with toileting. The resident was transferred to the toilet. During interview at this time, LPN #5 indicated the resident did not have Mepilex dressings on the skin, although the dressings were there "yesterday." No dressings were observed on the resident's brief or clothing. When interviewed as to whether staff assisting the resident with care had notified her the resident's dressings were not on the wounds, LPN #5 indicated, "No." LPN #5 obtained supplies and checked the physician's order. LPN #5 indicated the resident	F0309	**F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #A dressings to skin impaired areas are intact. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All Residents receiving treatment for skin impairment will be reviewed to ensure the treatment is in place. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Basic Wound Interventions. DHS or designee will re-educate the C.N.As on the following campus guidelines: CNA Responsibility in Wound Prevention. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will	01/05/2013

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	went to the wound center the previous day, so she wanted to be sure orders were unchanged. LPN #5 returned to the resident's room, and when the resident completed toileting, CNA #12 and LPN #5 assisted Resident A to stand next to the toilet for dressing changes. The wounds were observed on the resident's right and left upper thighs and onto the lower buttocks. The skin was red, and drops of blood were observed running down from the wounds. LPN #5 cleansed the areas normal saline and applied Mepilex dressings to the three areas. LPN #5 indicated the dressing to the resident's back also was not in place. Resident A indicated the area on the back "itches." LPN #5 indicated the resident picks at the dressing to the back. Resident A indicated she would pick at the dressing on her back, but she cannot reach it. Resident A indicated, "Most of the time I don't know it's on there." After the resident was transferred to her wheel chair and wheeled from the bathroom into her room, LPN #5 proceeded with care. With the resident seated in her wheel chair leaning forward, LPN #5 cleansed an area on the resident's mid-back with gauze and normal saline and applied a Hydrocolloid dressing. The area was a reddened line perpendicular to the spine and had three small wounds		be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: ensure skin impairment dressing / treatment is in place as ordered by MD - random all shifts.The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	along the line. LPN #5 indicated she thought the wound was caused by the resident's clothing being too tight across the area, and now new clothing had been purchased. CNA #12 indicated the resident's clothing had been "hard to get up and over the area" until the new clothing arrived. The clinical record for Resident A was reviewed on 12/5/12 at 12:45 p.m. An "Other Skin Impairment Assessment," for #2 wound to the "right inner (outer) thigh" indicated the following for the wound description on 11/30/12: 0.4 X 0.2 X < (less than) 0.1 cm (length by width by depth), tender, 100% red, and no signs and symptoms of infection. The Current Treatment indicated, "Mepilex," and the Medical Intervention indicated, "[name of local hospital] wound center." The Resident Care Plan, dated 11/21/12 for the problem of Skin Condition indicated Interventions including, but not limited to, the following related to "Excoriation Rt [right] inner (outer) thigh...Administer...preventative treatment as ordered." An "Other Skin Impairment Assessment," for #3 wound to the "left post [posterior] upper thigh" indicated the following for			

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	the wound description on 11/30/12: 2.5 X 0.5 X <0.1 cm, tender, 100% red, and no signs and symptoms of infection. The Current Treatment indicated, "Mepilex." The Resident Care Plan, dated 11/21/12 for the problem of Skin Condition indicated Interventions including, but not limited to, the following related to "Excoriation L [left] post upper thigh...Administer...preventative treatment as ordered." An "Other Skin Impairment Assessment," for #4 wound to the "left proximal thigh" indicated the following for the wound description on 11/30/12: "redness, [symbol for not] open," tender, 100% red, and no signs and symptoms of infection. The Current Treatment indicated, "Mepilex." The Resident Care Plan, dated 11/21/12 for the problem of Skin Condition indicated Interventions including, but not limited to, the following related to "Excoriation L proximal thigh...Administer...preventative treatment as ordered." A physician's order, dated 11/27/12, from the local hospital wound center indicated for Wounds #2, #3, and #4, "Cleanse Wound: Normal Saline; Dressing			

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	protocol and frequency: Mepilex border to wound, change dressing every 3 days and prn [as needed] dislodged." An "Other Skin Impairment Assessment," dated 11/11/12, indicated the wound to the resident's mid-lower back was observed as excoriation, tender, red, no exudate, and no odor, with measurements of 6 cm X 1 cm X <0.1 cm. Nurse's Notes related to the wound on the resident's back indicated the following: 11/12/12 at 11:00 a.m., "Area to mid back measures 6.3 cm X 0.6 cm X <0.1 cm. [symbol for no] exudate [symbol for no] s sx [signs and symptoms] of infection. Denies pain. Tx [treatment] Calmazine [protective ointment]. Have orders for res [resident] to go to wound center...." 11/19/12 at 10:30 a.m., "Area to mid back has divided into 3 smaller areas...." 11/26/12 at 1:00 p.m., "Areas to back have redeveloped into one area....small amount of serous exudate. [Symbol for no] odor. Wound bed is 25% yellow 75% pink...." A physician's order, dated 11/27/12, from the local hospital wound center indicated for Wound #5 Distal, medical back,			

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	"Cleanse Wound: Normal Saline; Dressing protocol and frequency: Hydrocolloid to wound, change weekly or prn dislodged. May tape border." During interview on 12/6/12 at 4:20 p.m., LPN #5 indicated she had noticed the resident's wounds were bleeding when she applied the Mepilex dressings on 12/5/12. This federal tag is related to Complaint IN00120307. 3.1-37(a)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure the resident's Foley catheter bag and tubing were positioned to help prevent urinary tract infection for 1 of 2 residents observed during care of the Foley catheter in a sample of 7. (Resident A) Findings include: On 12/5/12 at 1:45 p.m., LPN #5 and CNA #12 were observed assisting Resident A during transfer from the wheel chair onto the toilet in her bathroom. The resident was assisted to remove her soiled brief and don a clean brief, and the resident's Foley catheter bag was removed from its dignity bag and placed on the floor of the bathroom. Privacy was provided, and when Resident A indicated to staff that she was ready for personal care, LPN #5 and CNA #12 entered the bathroom. The Foley catheter bag was	F0315	**F 315 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident A catheter bag and tubing are positioned, and not placed on floor during care and transfers, to help prevent urinary tract infection (UTI). **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents with urinary catheter will be observed during care and transfers to ensure the catheter bag and tubing are positioned, and not placed on floor, to help prevent UTI. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate licensed nurses and C.N.As the following guideline: Urinary Catheter Care.**How the**	01/05/2013

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	lying on the floor. The resident was assisted to don a clean brief and stand for cleansing of the perineal area. The resident remained standing during cleansing and dressing applications to wounds on the upper thighs. The Foley catheter bag remained on the floor. The resident's clothing was adjusted, and she was assisted to transfer to the wheel chair. CNA #12 indicated she needed to empty the catheter bag and emptied the urine from the bag into a graduated cylinder. The catheter bag and tubing remained on the floor. LPN #5 began to turn Resident A's wheel chair to roll it out of the bathroom, and the wheel of the chair rolled onto the edge of the catheter bag lying on the floor, as CNA #12 indicated, "Let me get the catheter into the [dignity] bag." The clinical record for Resident A was reviewed on 12/5/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to, neurogenic bladder and history of urinary tract infection. A physician's order, dated 10/3/12, indicated, "U/A [urinalysis] C&S [culture and sensitivity] Indication - Dx [diagnosis] UTI [urinary tract infection]." A lab report for results of the culture and		**corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Residents with urinary catheter will be observed during care and transfers to ensure the catheter bag and tubing are positioned, and not placed on floor, to help prevent UTI - random all shifts. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	sensitivity, dated 10/5/12, indicated the resident's urine contained Escherichia coli and Proteus mirabilis (bacteria) susceptible to Cefazolin. A handwritten notation on the lab report indicated, "...Ceph [Cephalexin] 500 [mg] BID [twice daily] X 7 [days]...Re [check-mark] 72 [symbol for hours] [symbol for after] ATB [antibiotic]. A Resident Care Plan, dated 10/5/12, indicated, "Urinary Tract Infection." During interview on 12/6/12 at 3:25 p.m., Unit Manager #2 indicated the facility did not have a policy related to handling Foley catheter bags and tubing. Unit Manager #2 indicated the Foley catheter bag and tubing should not be on the floor. 3.1-41(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure the resident was supervised to prevent falls and a gait belt used for safe transfer for 1 of 2 residents observed during transfer in a sample of 7. (Resident D) Findings include: On 12/6/12 at 1:15 p.m., CNA #18 was observed assisting Resident D with toileting. CNA #18 disconnected the resident's chair alarm, and the resident was assisted to hold the support bar next to the toilet to stand and pivot onto the toilet. A gait belt was not used. The resident was observed to have loose brown stool on the buttocks and hips. A large yellowish-greenish area was observed on the left hip, and a wound with a bandage hanging off was observed on the left knee. When the resident completed toileting, CNA #18 assisted the resident to stand at the toilet while she used multiple wipes to cleanse stool from the resident's skin. The resident's right hand held the support bar next to the	F0323	**F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident D was observed during care to ensure supervision to prevent falls. Resident D was observed during transfer to ensure use of gait for safe transfers. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents identified as fall risk were observed during care to ensure supervision to prevent falls. All residents identified as fall risk and requiring assist were observed during transfer to ensure use of gait for safe transfers. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses and C.N.As on the following campus guidelines: Falls Management and Gait Belt Use. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The	01/05/2013

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	toilet. During the cleansing process, the resident's legs became wobbly, and the resident indicated her left leg was "getting weary." The resident's left knee was slightly bent. CNA #18 assisted the resident to be seated again on the toilet while the brief was applied. After the brief was applied, CNA #18 indicated it had become soiled from stool on the toilet seat. CNA #18 indicated she would obtain another brief and, leaving the resident seated on the toilet, entered the resident's room and obtained a brief from the closet. After the second brief was applied, the resident was assisted to stand and pivot from the toilet to the wheel chair. The resident's legs were shaking visibly, and CNA #18 held the back of the resident's pants and brief during the transfer. The resident indicated she wanted to go to bed. CNA #18 rolled the resident's wheel chair to the bed. CNA #18 held the sides of the resident's chest with her hands as she assisted the resident to stand, pivot, and be seated on the bed. The resident's legs were shaking. The clinical record for Resident D was reviewed on 12/5/12 at 3:55 p.m. A Fall Circumstance, Assessment and Intervention, dated 11/22/12, indicated the resident fell on 11/22/12 at 3:30 p.m. in the hallway. The document indicated		following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1). Residents, identified as fall risk, during care to ensure supervision to prevent falls - all shifts. 2). Residents, identified as fall risk and requiring assist, during transfer to ensure use of gait belt use for safe transfers - random all shifts. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	the resident was found on the floor with injury to the left knee and left hand. The IDT [Interdisciplinary Team] Review section of the form, dated 11/26/12, indicated, "Root cause: unassisted transfer attempt. Intervention update appropriate: 11/23/12 Change to: To remain in common area (encourage to) when up in W/C [wheel chair]." The Resident Care Plan, dated 10/12/12 indicated the resident was at risk for falls. Interventions included, but were not limited to, "Additional approaches: PSA [personal safety alarm] to bed and w/c [wheel chair]." During interview on 12/6/12 at 2:45 p.m., the Director of Health Services (DHS) indicated the facility's policy is to use a gait belt for a resident who bears weight during transfers. The DHS indicated lifts are used for residents who are not weight bearing. During interview on 12/6/12 at 2:45 p.m., Unit Manager #1 indicated the assistance of one staff person was appropriate for Resident D. She indicated a gait belt should be used. Unit Manager #1 indicated CNA #18 should not have left the resident unsupervised on the toilet while she obtained a brief. Unit Manager #1 indicated the aide should have used the			

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	call light to summon someone to obtain the brief for her. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2012
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure	F0441	**F 441 Corrective actions accomplished for those**	01/05/2013

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	staff washed hands and used gloves in accordance with infection control policies for 2 of 6 residents observed during care in a sample of 7 residents. (Resident A and Resident B) Findings include: 1. On 12/5/12 at 1:45 p.m., LPN #5 and CNA #12 were observed assisting Resident A with toileting. The resident was transferred to the toilet,. During interview at this time, LPN #5 indicated the resident did not have dressings on wounds to the thighs, and she would need to obtain supplies. LPN #5 removed her gloves, and without washing her hands or using hand sanitizer, left the resident's room and entered the hallway. LPN #5 petted a visiting dog in the hallway, entered the medication room, and obtained supplies from the treatment cart. She entered the clinical record office, checked the Treatment Record for physician's orders, and re-entered the resident's bathroom. LPN #5 washed her hands and provided dressing changes to four wounds. After completing care to a wound to the resident's back, LPN #5 removed her gloves. Without washing her hands or using hand sanitizer, she left the resident's room. In the hallway she talked with staff and residents, took paperwork from a visitor in the hallway,		**residents found to be affected by the alleged deficient practice:** LPN #5, C.N.A #4 and #26 were immediately coached / educated after this alleged deficient practice regarding the requirement of washing hands with soap and water or alcohol gel and glove use per the Standard Precautions and Hand Washing Guidelines. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by the same alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses and C.N.As on the following campus guideline: Standard Precautions and Hand Washing **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 staff members will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: During resident care to ensure hand washing and glove use protocols are followed per the Standard Precautions and Handwashing guideline - random all shifts. The results of the audit	

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	and entered the clinical record office. 2. On 12/6/12 at 1:45 p.m., CNA #4 and CNA #26 were observed providing incontinent care for Resident B. The resident's wet brief was removed and placed on the bedcovers at the end of the bed. Resident B was rolled to the left side, and CNA #4 cleansed the resident's anal area and buttocks and applied a protective barrier cream. She removed her gloves and placed them on the soiled brief at the end of the bed. Without washing her hands or using hand sanitizer, CNA #4 donned clean gloves and touched the soiled items on the bed, but did not pick them up. CNA #26 cleansed and applied protective barrier cream to the resident's penis and scrotum. Both CNA's then removed their gloves and without washing hands or using hand sanitizer, donned clean gloves and assisted the resident into his sweat pants. The facility's policy and procedure for Standard Precautions was provided by the Director of Health Services on 12/6/12 at 2:45 p.m. The policy indicated Procedure 3: "Gloves...e. Wash hands after removing gloves...." 3.1-18(l)		observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	