

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 05/18/2016
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NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA STREET COLUMBUS, IN 47203
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00200344 and IN00200258.</p> <p>Survey dates: May 11, 12, 13, 16, 17, & 18, 2016</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Census bed type: SNF: 37 SNF/NF: 25 Residential: 36 Total: 98</p> <p>Census payor type: Medicare: 22 Medicaid: 18 Other: 22 Total: 62</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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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F 0156 SS=E Bldg. 00	<p>Quality review completed by 30576 on May 25, 2016</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are</p>			

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	<p>made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of</p>			

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	<p>resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to provide liability notices in the appropriate time requirement to the residents who were discharged from skilled services for 4 of 4 residents reviewed. (Resident #5, #154, #164, & #177)</p> <p>Findings include:</p> <p>The Medicare benefits non-coverage notices for Resident #5, #154, #164, & #177 were reviewed on 05/17/2016 at 2:01 P.M.</p> <p>Resident #5's Medicare benefit non-coverage notice indicated the resident was notified on 12/09/2015 that coverage for services would end on 12/09/2015.</p> <p>Resident #154's Medicare benefit</p>	F 0156	<p>All resident admitted to facility within the last 30 days will be reviewed for 48 hour notices. All residents admitted to the facility with Medicare as their primary payor source, will be given a timely notice of their last covered day - 48 hours prior. All Medicare beneficiaries will be reviewed weekly in Medicare Meeting, by the Business Office Manager (BOM), Executive Director (ED), and Social Service Director (SSD), for need of a 48 hour notice that Medicare is ending. When notice is given, Social Services will make a copy for the Executive Director to review for timeliness. All copies will be placed in a binder and reviewed by the QA Committee monthly for 6 months. The Business Office will provide a list of discharged Medicare residents to the QA committee to ensure all residents were provided a notice of last covered day, 48 hours in</p>	06/17/2016	

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	<p>non-coverage notice indicated the resident was notified on 03/20/2016 that coverage for services would end on 03/21/2016.</p> <p>Handwritten documentation on the notice indicated the resident's wife received and understood this notice, dated 03/21/2016.</p> <p>Resident #164's Medicare benefit non-coverage notice indicated the resident was notified on 04/20/2016 that coverage for services would end on 04/20/2016.</p> <p>Resident #177's Medicare benefit non-coverage notice indicated the resident was notified on 05/09/2016 that coverage for services would end on 05/08/2016.</p> <p>During an interview on 05/17/2016 2:05 P.M., SSA (Social Services Assistant) indicated resident's were to be given 48 hour notice prior to the end of coverage. SSA further indicated if the resident or family member can not sign the form promptly a note was documented in the resident's progress notes or a handwritten note was directly placed on the notice form.</p> <p>During an interview on 05/18/2016 at 11:05 A.M., The Administrator indicated resident's should be given at least 48</p>		<p>advance. Business office and Social Service staff will be educated on new procedure on notices to ensure compliance. Any non-compliance will be addressed thru re-education or counseling.</p>				

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F 0279 SS=D Bldg. 00	<p>hours notice prior to the discharged from skilled services.</p> <p>The current facility policy, titled "Advance Beneficiary Notice of Non-coverage (ABN)", was provided by the SSA on 05/18/2016 at 3:49 P.M. and was reviewed at that time. The policy indicated, "...Must be issued no later than 2 days in advance of [last covered day]"..."Note: If the note is given with a shorter timeframe, the notice could be considered invalid..."</p> <p>3.1-4(f)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services</p>			

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	<p>that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to ensure comprehensive care plans were created related to psychotropic medications for 2 of 27 residents reviewed for care plans. (Resident #122 and #81)</p> <p>Findings include:</p> <p>1. Record review for Resident #122 was conducted on 05/13/2016 at 2:09 P.M. The most recent quarterly MDS (Minimum Data Set) assessment, dated 04/05/2016, indicated an antianxiety medication was given during six of seven days and an antidepressant medication was given seven of seven days during the look back period. Resident #122's diagnoses included, but were not limited to, anxiety disorder, depression, and malnutrition.</p> <p>Resident #122's comprehensive care plans were reviewed on 05/13/2016 at 2:09 P.M. and did not include care plans for the diagnoses of anxiety and depression or for use of antianxiety and antidepressant medication.</p> <p>During an interview on 05/13/2016 at</p>	F 0279	<p>Psychotropic care plans were immediately updated to reflect the use of psychotropic medications for residents #122 and #81 by the MDS coordinator. All residents receiving psychotropic medications have the potential to be affected. All residents that currently receive psychotropic medication were reviewed by the MDS coordinator and care plans were developed to reflect measurable objectives and timetables to meet the residents psychosocial needs. MDS Coordinator and Social Services Assistant will be educated on Guidelines for Care Plan Development by 6/17/16. Random audits of psychotropic care plans will be conducted by the MDS coordinator 5x/week for 4 weeks then 3x/week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Results of audits will be reported, reviewed, and trended for compliance through the QA committee for a minimum of 6 months, then randomly thereafter until substantial compliance is achieved. Corrective action completion date: 6/17/16.</p>	06/17/2016	

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	<p>2:39 P.M., the MDS Coordinator indicated there should be care plans for any psychoactive medications a resident was taking.</p> <p>During an interview on 05/17/2016 at 1:31 P.M., the SSA (Social Services Assistant) indicated it was her responsibility to create care plans for Resident #122's psychoactive medication use and diagnoses. She further indicated she had lost track of time and the care plans had not been created.</p> <p>2. Resident #81's record was reviewed on 5/13/16 at 9:45 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, anemia, hypertension, major depression and Crohn's disease.</p> <p>The current care plan, dated 1/25/16, included interventions relative to Resident #1's Alzheimer's diagnosis, but there were no care plan interventions in place to address dementia with agitated features.</p> <p>The physician's order, dated 3/25/15, was Risperidone (an antipsychotic medication) 0.25 mg, ½ tab (0.125 mg) twice a day for dementia with agitated features.</p>			

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	<p>On 5/13/16 at 2:00 p.m., during an interview RN (Registered Nurse) #6 indicated he was not certain but thought the medication, Risperidone, was prescribed to Resident #1 when the resident was initially admitted and displayed irritable behaviors such as kicking the chairs of other residents. The resident was admitted on 12/1/2014.</p> <p>On 5/16/16 at 9:30 a.m., during an interview Resident #81 was slow to respond and indicated he was tired.</p> <p>On 5/17/16 at 11:00 a.m., during an interview CNA (Certified Nursing Assistant) #7 indicated she had not seen or heard of Resident #81 displaying negative behaviors and indicated he was usually tired and had not wanted to interact much.</p> <p>On 5/17/16 at 11:15 a.m., during an interview RN #6 indicated behavioral issues were charted in progress notes and event notices for follow up. He indicated he could not recall the last behavioral incident for Resident #81. RN #6 indicated he was not aware of a care plan in place regarding behaviors relative to the use of Risperidone.</p> <p>On 5/17/16 at 2:20 p.m., during an interview the Social Services Assistant</p>			

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F 0323 SS=E Bldg. 00	<p>indicated she was not sure why the resident was still on Risperidone, or if there was a care plan in place for behaviors associated with dementia or Alzheimer's. She indicated a care plan should be in place for the identified problem areas requiring an antipsychotic medication.</p> <p>On 5/18/16 at 2:00 p.m., a review of the Guidelines For Care Plan Development, dated June 2013 indicated "A care plan shall be developed no later than 21 days after admission, and no later than 7 days after the date..., addressing the resident preferences, MDS triggers, diagnoses, risk factors and other applicable care needs."</p> <p>3.1-35(a)</p> <p>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, interview and record review, the facility failed to</p>	F 0323	No residents were affected by this deficiency. The kitchenette doors	06/17/2016			

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	<p>protect residents from possible hazards related to an unattended griddle and steam table, improper sharps handling, and improperly stored and disposed of medication. This had the potential to affect 30 of 62 residents who were independently mobile.</p> <p>Findings include:</p> <p>1. During the initial tour on 05/11/2016 at 10:15 A.M., the Nourishment room in the 600 hall was unlocked, the steam table and griddle were turned off and emitting no heat.</p> <p>During an observation on 05/11/2016 at 11:17 A.M., the Nourishment room was unlocked with no staff nearby. The griddle temperature was set on 375 degrees and giving off heat. The steam table was turned on and giving off heat. The door from the hallway and the double doors from dining area were both unlocked.</p> <p>During an interview on 05/11/2016 at 11:22 A.M., the DON (Director of Nursing) indicated she did not know if the room was supposed to be left open. The Unit Manager for Transitional Care also indicated she did not know if the room should have been unlocked.</p>		<p>on the 600 Hall (Cummins Blvd) will be locked except when in use for meal service. There will be a key kept on the side door entrance to the kitchenette, so that staff will have access. All staff will be inserviced on this policy. Dietary staff will be inserviced on company policy and procedure regarding equipment safety. The griddle and/or steam table will not be turned on unless doors are locked, or there are staff in the kitchenette to monitor the equipment. The Director of Food Service (DFS) and/or their designee, or the Executive Director will monitor and document compliance with this policy and procedure. Any non-compliance will be addressed with re-education or counseling. IV stock cart was immediately placed behind a lock door on both days it was found unattended in the hallways. Supplier of the IV cart was notified on both 5/11/16 and 5/16/16 to request a new IV stock cart be delivered. Key lock was placed on IV stock cart on the afternoon of 5/16/16 by supplier. All ambulatory residents have the potential to be affected. Licensed staff will be in-serviced on accident hazards by 6/17/16. Random audits of Locked IV stock cart will be conducted by DHS, ADHS, or Unit manager 5x/week for 4 weeks then 3x/week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Results of audits will be</p>	

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	<p>During an interview on 05/11/2016 at 11:24 A.M., Cook #10 indicated the doors were always left unlocked so staff could get into the refrigerator. He further indicated there was nothing to prevent residents from going in the room. The cook indicated staff go in and turn on the griddle, but did not stay and monitor the griddle after it was turned on. He had to unplug the griddle to get it to turn off.</p> <p>The current "Portable Cooking Equipment Guidelines" policy, dated 02/2012, was provided by the Payroll Administrator on 05/18/2016 at 2:00 P.M. and reviewed at that time. The policy indicated "...Under no circumstances is portable cooking equipment to be left unattended by untrained team members."</p> <p>2. During an observation on 05/11/2016 at 12:25 P.M., an IV (intravenous) stock cart was left in a short hallway off the 600 hall. The IV cart was not locked and contained supplies that included, but were not limited to, IV start needles, IV fluid bags, and general IV supplies.</p> <p>During an observation on 05/16/2016 at 7:51 A.M., an IV stock cart was left in the hall by the main nurses station. The IV cart was not locked and contained supplies that included, but were not</p>		<p>reported, reviewed, and trended for compliance through the QA committee for a minimum of 6 months, then randomly thereafter until substantial compliance is achieved. Corrective action completion date: 6/17/16. Unsecured sharps container, disposable razors, and shaving cream were immediately removed from the shower room by DHS and ADHS. Full sharps container on medication carts were removed and replaced with new disposal containers. DPO was notified and an order was placed for a sharps disposal device capable of being affixed to the wall. All residents have the potential to be affected. Licensed staff will be in-serviced on keeping the shower room door closed/locked while unattended. DPO will hang sharps disposal locking device in the shower room by 6/17/16. Licensed staff will be in-serviced on accident hazards, syringe and needle disposal, and disposal of contaminated sharps by 6/17/16. Random audits of sharps storage, disposal, and containment will be conducted by DHS, ADHS, or unit manager 5x/week for 4 weeks then 3x/week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Results of audits will be reported, reviewed, and trended for compliance through the QA committee for a minimum of 6 months, then randomly thereafter until substantial compliance is</p>	

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	<p>limited to, IV start needles, IV fluid bags, and general IV supplies.</p> <p>During an interview on 05/11/2016 at 12:41 P.M., the DON (Director of Nursing) indicated the IV stock cart did not have a lock.</p> <p>3. During an observation on 05/16/2016 at 7:53 A.M., the door to the bath room on the 200 hall was left open with no staff or residents inside. On a set of shelves along the wall of the room there was an unsecured sharps container, three unused disposable razors, two sets of nail clippers, and a basket of new shaving cream cans.</p> <p>During an interview on 05/16/2016 at 7:56 A.M., CNA #12 indicated the door was usually kept shut and razors were supposed to be secured in the closet.</p> <p>The current facility policy, titled "Syringe and Needle Disposal" and dated 9/1/13, was provided by the DON on 05/16/2016 at 3:55 P.M. and was reviewed at that time. The policy indicated, "...kept in the medication room or affixed to the medication cart...full containers of discarded needles are kept where residents and unauthorized staff do not have access..."</p>		<p>achieved. Corrective action completion date: 6/17/16.</p> <p>Polyethylene glycol was immediately removed and placed back in the medication cart by the ADHS. RN #6 was verbally educated by ADHS on proper storage of medications. Trash can containing the orange pill was immediately changed and placed in the soiled utility room for disposal by the ADHS. Orange pill was placed in the sharps container by ADHS. LPN #11 was verbally educated by ADHS on proper disposal of medications. All ambulatory residents have the potential to be affected. Licensed staff will be in-serviced on medication storage and guidelines for disposal of non-controlled drugs by 6/17/16. Random audits on medication storage and disposal will be conducted by DHS, ADHS, or unit manager 5x/week for 4 weeks then 3x/week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Results of audits will be reported, reviewed, and trended for compliance through the QA committee for a minimum of 6 months, then randomly thereafter until substantial compliance is achieved. Corrective action completion date: 6/17/16.</p>		

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	<p>4. During an observation on 05/16/2016 at 8:01 A.M., the full sharps container on a 600 hall medication cart was unsecured, with the container door unlocked and hanging open.</p> <p>Following medication administration on 05/16/2016 at 8:29 A.M., LPN #3 returned to the medication cart with a used medication needle. The LPN pulled down the cover that indicated the sharps container was full and dropped the needle into the container. The LPN indicated the sharps container was not supposed to be unlocked and proceeded to lock the container.</p> <p>During an interview on 05/16/2016 at 3:23 P.M., the DON and ADON indicated sharps containers should be locked and and the inner liners secured. The DON and ADON further indicated sharps containers should be changed out when the container indicated it was full.</p> <p>The current facility policy, titled "Disposal of Contaminated Sharps", was provided by the Administrator on 05/18/2016 at 2:55 P.M. and was reviewed at that time. The policy indicated, "...Sealed and replaced when they are 75% to 80% full to protect employees from punctures..."</p>			

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	<p>5. During an observation on 05/11/2016 at 10:02 A.M., a bottle of polyethylene glycol (laxative) was left unattended on top of a medication cart in the 100 hall while RN #6 was in a resident's room.</p> <p>During an observation on 05/11/2016 at 10:14 A.M., RN #6 left the 100 hall medication cart to retrieve a supplement for a resident. The bottle of polyethylene glycol was still on top of the 100 hall medication cart.</p> <p>During an interview on 05/11/2016 at 10:15 A.M., the ADON (Assistant Director of Nursing) took the bottle of polyethylene glycol off the top of the medication cart and indicated medications were not to be left on medication carts and the bottle did still have medication inside.</p> <p>During an interview on 05/11/2016 at 10:16 A.M., RN #6 indicated medications were not supposed to be left out on top of medication carts and the bottle of polyethylene glycol should have been put back into the cart.</p> <p>6. During an observation on 05/11/2016 at 2:37 P.M., a round, orange pill was in the trash can of the 300 hall medication cart.</p>			

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	<p>During an interview on 05/11/2016 at 2:38 P.M., LPN #11 indicated she had dropped the orange pill earlier and had thrown it in the trash can instead of in the sharps container where it was supposed to go.</p> <p>During an interview on 05/16/2016 at 3:23 P.M., the DON and ADON indicated dropped pills should be put in the sharps container or flushed, not put in the trash.</p> <p>The current facility policy, titled "Guidelines for Disposal of Non-Controlled Drugs" and dated 4/2013, was provided by the DON on 05/16/2016 at 3:55 P.M. and was reviewed at that time. The policy indicated, "...Medications that have been dropped, removed from the container in error or otherwise requires disposal may be placed in the sharps container or mixed in kitty litter, coffee grounds or similar product with water and disposed of in the waste canister to insure they are not obtainable to other residents..."</p> <p>3.1-45(a)(1)</p>			

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F 0371 SS=E Bldg. 00	<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</p> <p>Based on observation, interview, and record review, the facility failed to correctly label stored food items per facility policy. In one of two nourishment rooms observed. (Cummins Boulevard 600 hall.)</p> <p>Findings include:</p> <p>On 05/13/2016 at 12:20 p.m., the nourishment room on Cummins Boulevard was observed, the upper cabinet above the sink contained two 1/4 loaves of bread opened in original packaging. There was no indication of a label to identify the name of the item, date and time the food was labeled, initials of person labeling the item. There were four loaves of unopened bread with no label and no expiration date on original package. Three bags of cereal were opened with no label to identify the cereals. Also there were four one gallon plastic containers containing dry cereal with no labels. A 3/4th's full</p>	F 0371	<p>No residents were adversely affected by this deficiency. All items mentioned in survey (bread, cereal, and yellow butter substitute) will be properly stored and labeled. Standardized labels will be utilized by staff and will contain item name, date and time the food was labeled, use by date, and initials of the person labeling. All staff will be inserviced on this policy and procedure. Bread - is a frozen product from GFS (Gordon Food Service) and has no expiration date, until it is thawed. At time of thawing, shelf life is 7 days. After the thawed package is opened, shelf life is then 3 days. Cereal - Cereal will be purchased in individual RTS (ready to serve), sealed bowls that have a pre-printed manufacturers expiration date. Butter Substitute - The substitute comes in gallon containers with a manufacturers expiration date. When the liquid is poured into squeeze bottles for use by staff, it will expire 30 days from that day. Director of Food Service or their designee, or the Executive Director, will monitor and document compliance by daily</p>	06/17/2016

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	<p>squeeze bottle that contained a bright yellow liquid substance was stored in the upper cabinet with no label.</p> <p>On 05/16/2016 at 8:59 a.m., the nourishment room in Cummins Boulevard was observed. The cabinet above the sink contained two 1/4 loaves of bread with no label, and also four loaves of unopened bread with no label. No expiration date on the breads' original packaging were found. Also there were 3 bags of cereal opened with no label and four one gallon plastic containers with dry cereal and no label. The 3/4th's full squeeze bottle with bright yellow liquid substance was in the upper cabinet with no label.</p> <p>On 5/16/2016 at 9:24 a.m., Dietary manager provided "Trilogy Health and Services Food labeling and Dating Policy" which indicated "FOOD LABELING: Any food product: Removed from its original container, has the seal broken, that has been processed in any way. MUST have a label that contains the following: Item name, Date and Time (that the food was labeled), Use by Date, Initials of the person labeling the item, Securely cover food item, use the same label at all times and in all areas."</p> <p>On 05/16/2016 at 11:41 a.m., during an</p>		<p>rounding 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then 1 day per week for 4 weeks, and at least twice monthly thereafter. All documentation will be reviewed monthly in QA for 6 months and randomly thereafter until substantial compliance is achieved. Any deficient practice will be addressed by re-education or counseling.</p>	

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	<p>interview and tour with the Dietary Manager, he indicated staff did not label as it was used so quickly. He also indicated the yellow liquid observed in the cabinet was liquid butter, which staff usually did not label.</p> <p>On 05/16/2016 at 1:35 p.m., The Dietary Manager provided and referred to the "Original Liquid Butter" container's label which indicated this butter did not need to be refrigerated. The original container was labeled with a date opened. The Dietary Manager also indicted staff changed out the liquid butter daily and that was her reason it was not labeled.</p> <p>On 05/16/2016 at 2:13 p.m., Dietary Manager provided manufacturer information for GFS Liquid Butter Alternative. This quality soybean oil acts as a butter alternative, while still providing a buttery flavor and golden color, ideal for sauteing, basting, pan and griddle frying, it contains soy lecithin to prevent food from sticking to cooking utensils. The product never needs to be refrigerated.</p> <p>On 5/16/2016 at 9:24 a.m., the "Trilogy Health Services Food Labeling and Dating Policy" was provided by the Interim Social Services Directors, not dated, and currently being used. It</p>			

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F 0441 SS=D Bldg. 00	<p>indicated, Food Labeling: Any food product: Removed from its original container, has a broken seal that has been processed or prepared in any way. MUST have a label that contains the following: Item name, date and time (that food was labeled), use by date, initials of the person labeling the item. Securely cover the food item. Use the same label at all times and in all areas.</p> <p>3.1-21(i)(1)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>			

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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control measures were followed related to administering transdermal medication patches and handwashing during medication administration for 2 of 6 residents observed during medication administration. (Resident #166 and #169)</p> <p>Findings include:</p> <p>1. During an observation on 05/16/2016 at 8:29 A.M., LPN #3 prepared</p>	F 0441	<p>LPN #1 was verbally educated on proper handwashing and transdermal patch application guidelines. All residents have the potential to be affected. Licensed staff will be inserviced on Transdermal patch application, Administration procedures for all medications, and guidelines for hand washing/hand hygiene by 6/17/16. Random audits of transdermal patch application, medication pass, and handwashing will be conducted by the DHS, ADHS, or unit manager 5x/week for 4 weeks then 3x/week for 4 weeks, then weekly for 4</p>	06/17/2016

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	<p>medication for Resident #166. After administering the resident's medications, LPN #3 reached down the back of Resident #166's gown and, with her bare hands, removed the previously used nicotine patch. Without donning gloves, LPN #3 peeled the back cover off the new nicotine patch, touching the medicated side of the patch with her thumb, before applying the patch to the resident's back. The LPN then assisted Resident #166 to roll on her side before peeling the back cover off a lidocaine transdermal patch and applying it to the resident's back.</p> <p>During an interview on 05/16/2016 at 3:55 P.M., LPN #1 indicated the medicated side of the transdermal patch was not to be touched and that gloves were to be worn during application of patches.</p> <p>During an interview on 05/17/2016 at 2:57 P.M., RN #4 indicated gloves should be worn when medication patches were applied. She further indicated medication patches should not be touched with bare hands.</p> <p>The current facility policy, titled "Transdermal Drug Delivery System (Patch) Application and dated 9/1/13, was provided by the Administrator on</p>		<p>weeks, then monthly for 6 months. Results of audits will be reported, reviewed, and trended for compliance through the QA committee for a minimum of 6 months, then randomly thereafter until substantial compliance is achieved. Corrective action completion date: 6/17/16.</p>		

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	<p>05/16/2016 at 10:50 A.M. and was reviewed at that time. The policy indicated, "...Wearing gloves, remove new patch from package and envelope..."</p> <p>2. During an observation of medication administration on 05/16/2016 at 8:50 A.M., LPN #2 administered medications to Resident #171. After administering the medications, the LPN threw away the trash, tied her shoe, and washed her hands for nine seconds. The LPN then began preparing medications for resident #169.</p> <p>During an interview on 05/17/2016 at 2:57 P.M., RN #4 indicated during medication administration, hands were washed or hand sanitizer was used before pulling medications from the cart and after administering medications. The RN further indicated hands should be scrubbed for 11 seconds.</p> <p>During an interview on 05/17/2016 at 3:03 P.M., CNA #5 indicated hands should be washed for 20 seconds.</p> <p>The current facility policy, titled "Guideline for Handwashing/Hand Hygiene" and dated 8/2014, was provided by the DON (Director of Nursing) on 05/16/2016 at 3:55 P.M. and reviewed at that time. The policy indicated, "...Wash</p>			

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F 0503 SS=C Bldg. 00	<p>well for 20 seconds...using a rotary motion and friction..."</p> <p>The current facility policy, titled "Administration Procedures for All Medications" and dated 9/1/13, was provided by the Administrator on 05/16/2016 at 10:50 A.M. and was reviewed at that time. The policy indicated, "...Cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning a med [medication] pass..."</p> <p>3.1-18(l)</p> <p>483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.</p> <p>If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.</p> <p>If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the</p>			

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	<p>requirements of part 493 of this chapter.</p> <p>If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.</p> <p>Based on observation, interview and record review, the facility failed to ensure the CLIA (Clinical Laboratory Improvement Amendments) waiver was current and active. This had the potential to affect 62 of 62 residents who resided in the building.</p> <p>Findings include:</p> <p>During the initial tour on 05/11/2016 at 11:02 A.M., the framed CLIA waiver located in the entrance lobby had an expiration date of 03/23/2016.</p> <p>During an interview on 05/12/2016 at 3:42 P.M., the Administrator indicated the CLIA waiver was expired, but that is was supposed to be renewed before the expiration date.</p> <p>A copy of the current facility CLIA waiver was provided by the Administrator on 05/12/2016 at 2:35 P.M. The waiver had an expiration date of 03/23/2016.</p> <p>3.1-49(b)</p>	F 0503	<p>No residents were affected by this deficiency. On 5-12-16, during the survey, CMS was contacted by the facility, and payment was made online to renew the CLIA waiver. The new CLIA waiver was received by the facility on 5-23-16, and posted within the building. The QA Committee will monitor the status of the CLIA waiver by reviewing each month, and it will also be monitored thru the bi-annual Peer Review process.</p>	06/13/2016

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F 9999 Bldg. 00	<p>410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28--13-3. This rule is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to document Reference Checks for 2 of 10 employee records reviewed. (CNA, Certified Nurse Aide, #8 and #9)</p> <p>Findings include:</p> <p>The employee records were reviewed on 05/17/2016 at 9:00 A.M. CNA #8 and #9 had no references listed in their employee files.</p> <p>During an interview on 05/17/2016 at 10:22 A.M., the Payroll Administrator</p>	F 9999	The facility has contracted with Justifax to perform all employee reference checks prior to their hire. All current employee files will be reviewed to ensure they have proper documentation of references. Executive Director or Business Office Manager will audit new employee hires for reference checks one time per week for 8 weeks, then two times per month for two months. The QA Committee will do an audit of new employee files each month to ensure they contain references.	06/17/2016

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NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA STREET COLUMBUS, IN 47203
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R 0000 Bldg. 00	<p>indicated CNA #8 and #9 did not have any references listed in their employee records. She further indicated there had been a time period when staff were calling references on the phone but failed to document the information. She could not verify that reference checks had been done on the two specific employees.</p> <p>During an interview on 05/18/2016 at 1:43 P.M., the Administrator indicated the CNAs were hired before the the facility started using the current background check company which included reference checks in their process. She further indicated any phone references that may have been done on the CNAs were not documented by the staffing coordinator.</p> <p>The current Reference Checks policy, dated 5/21/09, was provided by the Administrator on 05/18/2016 at 1:50 P.M., and reviewed at that time. The policy indicated "...The Company will complete reference checks on all applicants."</p>	R 0000		
	This visit was for a State Residential			

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R 0086 Bldg. 00	<p>Licensure Survey.</p> <p>Residential Census: 32 Sample: 7</p> <p>These deficiencies reflect State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on observation, interview and record review, the facility failed to ensure the CLIA (Clinical Laboratory Improvement Amendments) waiver was current and active. This had the potential to affect 62 of 62 residents who resided in the building.</p> <p>Findings include:</p>	R 0086	No residents were affected by this deficiency. On 5-12-16, during the survey, CMS was contacted by the facility, and payment was made online to renew the CLIA waiver. The new CLIA waiver was received by the facility on 5-23-16, and posted within the building. The QA Committee will monitor the status of the CLIA waiver by reviewing each month,	06/13/2016

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R 0156 Bldg. 00	<p>During the initial tour on 05/11/2016 at 11:02 A.M., the framed CLIA waiver located in the entrance lobby had an expiration date of 03/23/2016.</p> <p>During an interview on 05/12/2016 at 3:42 P.M., the Administrator indicated the CLIA waiver was expired, but that is was supposed to be renewed before the expiration date.</p> <p>A copy of the current facility CLIA waiver was provided by the Administrator on 05/12/2016 at 2:35 P.M. The waiver hand an expiration date of 03/23/2016.</p> <p>410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24.</p> <p>Based on observation, interview, and record review the facility failed to ensure stored food items were labeled correctly per facility policy in one of one nourishment rooms observed in the locked unit.</p> <p>Findings include:</p>	R 0156	<p>and it will also be monitored thru the bi-annual Peer Review process.</p> <p>No residents were adversely affected by this deficiency. All items mentioned in the survey (salad, plate of fruit, ice, etc.) were removed from the refrigerator and disposed of. Any future items stored in the refrigerator or in the cabinet above the sink, will have appropriate labels on them, with date, use by date, initials, item name, time. The refrigerator and cabinets will be monitored by the</p>	06/17/2016	

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	<p>On 5/18/2016 at 1:19 p.m., the nourishment room in the locked unit was observed with the following: In the refrigerator, the following items were observed with no labeling information: one plate of sliced fruit, covered with plastic wrap, one bowl of thick orange liquid substance with loose clear plastic wrap, one small bowl of thick white liquid substance wrapped with loose clear plastic wrap, four 1/2 gallon containers-each 1/2 full with one containing a red liquid, one with an orange liquid, one with a purple liquid, and one with a clear liquid, one 1/2 gallon container 1/4 full with a yellow liquid, a plastic bucket full of ice with the ice scoop stored within the ice and covered with plastic wrap, a plate of salad with a variety of vegetables on the bottom shelf covered with plastic wrap. There were two open containers of thickened liquid in the door shelf with an original label of thickened cranberry and thickened orange and a small bowl of greenish salad covered with plastic wrap without labels. In the cabinet above the sink, one half bag of dry cereal and one clear squeeze bottle 1/4 full containing a liquid yellow substance with no labels.</p> <p>On 5/16/2016 at 9:24 a.m., Interim Social Services Director provided the "Trilogy Health Services Food Labeling and</p>		<p>third shift staff on the Legacy Unit to ensure no improperly labeled items were placed in it. The Legacy Lane Coordinator, Director of Health Service, or designee will monitor and document to ensure compliance is achieved. QA committee will review the documentation in monthly QA meeting for 6 months, and then randomly thereafter to ensure compliance. Any deficient practice will be addressed by re-education or counseling.</p>	

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	<p>Dating Policy" not dated, and currently being used. It indicated, Food Labeling: Any food product: Removed from its original container, has a broken seal that has been processed or prepared in any way. MUST have a label that contains the following: Item name, date and time (that food was labeled), use by date, initials of the person labeling the item. Securely cover the food item. Use the same label at all times and in all areas.</p>			