

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  04/15/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 7 - 11, 14 &amp; 15, 2014</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Survey team: Brenda Buroker, RN, TC (4/7-11, 2014) Julie Dover, RN (4/7-11 &amp; 13, 2014) Jennifer Carr, RN (4/9, 10, 14 &amp; 15, 2014) Angela Halcomb, RN (4/7-11, 2014)</p> <p>Census bed type: SNF 43 SNF/NF 25 Residential 35 Total: 103</p> <p>Census payor type: Medicare 26 Medicaid 19 Other 58 Total: 103</p> <p>Sample: Residential Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Silver Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	

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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F000156 SS=C	<p>Quality Review completed on 4/21/14, by Brenda Meredith, R.N. 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 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>				

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	<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 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</p>			

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	<p>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 to the residents who were discharged from skilled services for three of three residents reviewed. (Resident #s 4, 12, 42)</p> <p>Findings include:</p> <p>The Business Office Manager was requested on 4/10/14 at 3 p.m. to provide the liability notices for three residents, Resident #s 4, 12, and 42, who had been discharged from skilled therapy services. The administrator stated on 4/11/14 at 10 a.m., the facility does not provide liability notices to any resident. He stated he had checked with therapy and the Advanced Beneficiary Notice was not provided at this facility.</p> <p>Review of the Facility Census Form provided by the facility on 4/7/14 at 12 noon indicated the facility had 43 residents in SNF/Medicare only beds. The Resident Census and Condition of Residents form completed by the facility on 4/7/14 at 12 noon indicated 38 residents were receiving Rehabilitation Services.</p>	F000156	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Residents #4, #12, and #42 were discharged before this plan. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents receiving Medicare A Benefits and receiving skilled care have the potential to be affected by the same alleged deficient practice. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: Executive Director or Designee will inservice the Social Services Department staff on the requirements of issuing liability notices to residents being discharged from skilled services. In-service scheduled for May 5, 2014. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT</p>	05/15/2014			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES 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 interview and record review, the facility failed to ensure residents were given a choice regarding daily care decisions important to them. This affected three of three residents reviewed for choices in a sample of six. (Residents #106, #116 and #6)</p> <p>Findings include:</p> <p>1. Interview with Resident #106 on 4/8/14 at 3:15 p.m. indicated the resident was not given a choice regarding how many times a week she took a bath or shower. She reported "they just come."</p>	F000242	<p>PRACTICE DOES NOT RECUR:Executive Director or Designee will audit one resident discharged from skilled services each week for 1 month, then monthly for 5 months to ensure that liability notices were issued correctly. Findings will be reported to the QA Committee each month for review and further recommendations. (attachment F-156)COMPLETING DATE:On or before 5-15-14</p> <p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:There were no adverse outcomes to any residents as a result of the alleged deficient practice. Residents #6, #106, and #116 had their I-Care Plans updated to reflect their personal preferences.IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE</p>	05/15/2014

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	<p>Interview, on 4/10/14 at 11:35 a.m., with C.N.A. #1 who cared for Resident #106 indicated she knew who received showers by the names on the assignment sheet. She indicated that if a resident refused a shower or bath or said they did not want it at a particular time, she would encourage them to take the shower anyway. If they were still insistent in not taking the shower, she would return at a later time.</p> <p>Interview with the DON (Director of Nursing), on 4/10/14 at 11:00 am, indicated they had just realized they completed the forms for Resident Preference, but the information did not get transferred to the care plan and did not get to the CNA assignment and they will change this process.</p> <p>2. Interview with Resident #116, on 4/7/14 at 1:55 p.m., indicated she did not get to choose how many times she received a bath or shower, when to go to bed or get up.</p> <p>She indicated that they come in tell her it is bed bath time, they come in to put her to bed in their time schedule, and had never been asked for her choice in these matters.</p> <p>Record review, on 4/10 14 at 10 a.m., indicated the Activity staff completed the Resident Preference for Customary Routine and Activities Interview Worksheet on 8/14/13. The resident was asked: While you are at the facility? How important is it to you.... to chose what clothes you wear: To take care of your personal things and belongings, chose between a bed bath, tub bath, shower or sponge bath? " Very important" was checked for each of these questions.</p>		<p>ACTIONS TAKEN:All residents have the potential to be affected by the same alleged deficient practice. DHS or Designee will review the medical records of all residents to ensure that residents personal preferences are included in the I-Care Plans.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will re-educate the MDS Coordinator and the Nursing Unit Managers on entering residents personal preferences in the residents I-Care Plans.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit 5 residents charts weekly for 1 month, then bi-weekly for 2 months, then monthly for 3 months. Findings will be reported to the QA Committee each month for review and further recommendations if necessary. (attachment F-242)COMPLETING DATE:5-15-14</p>				

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	<p>Which type of bath do you prefer? "bed bath"</p> <p>What time of day do you bathe? "late afternoon"</p> <p>How important is it to chose your own bedtime? "very important"</p> <p>What time do you normally wake up? "7 or 8"</p> <p>Go to bed? "12 or 1"</p> <p>Interview with the DON, on 4/10/14 at 11:00 a.m., indicated they had just realized they completed the forms for Resident Preference, but the information did not get transferred to the care plan and did not get to the CNA assignment. They will change this process.</p> <p>3. Interview with Resident #6, on 4/8/14 at 9:50 a.m., indicated she did not get to choose how many times a week she took a bath or shower.</p> <p>Clinical Record review, on 4/10/14 at 9 a.m., indicated the Activity staff completed the "Resident Preference for Customary Routine and Activities Interview Worksheet" on 6/12/13.</p> <p>The resident was asked: While you are at the facility? How important is it to you... to chose what clothes you wear? to take care of your personal things, chose between a bed bath, shower or tub The resident responded "Very important" all the questions.</p> <p>Which type is preferred? "sponge, early afternoon"</p> <p>The resident responded it was very important to choose bedtime and that time was 10 p.m.</p>			

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F000246 SS=D	<p>None of these care requests were on the plan of care.</p> <p>Interview with the DON, on 4/10/14 at 11:00 am, they had just realized they completed the forms for Resident Preference, but the information did not get transferred to the care plan and did not get to the CNA assignment. They will change this process.</p> <p>3.1-3(u)(3) 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview, the facility failed to provide reasonable accommodation of individual needs for 3 residents who were dependent on staff for activities of daily living (ADL's) in that they did not have call lights within reach. (Residents #22, #21, and #51.)</p> <p>Findings include:</p> <p>On 4/9/2014 at 9:48 a.m., Resident #22 was observed in her room, sitting in her wheelchair, with her call light on the floor 1-2 feet away from her and not within reach.</p> <p>On 4/9/2014 at 3:10 p.m., Resident #22 was observed in her room, sitting with her eyes closed in her wheelchair in the center of her side of the shared room. Her call light was</p>	F000246	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Residents #21, #22, and #51 had their call lights placed within reach. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents who are dependent on staff for ADL's have the potential to be affected by the same alleged</p>	05/15/2014

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	<p>observed to be out of reach; hanging over her bed towards the opposite wall. CNA #2 was called to the room to observe Resident #22's position in the room and the location of her call light. CAN #2 indicated that Resident #22's call light was not within her reach.</p> <p>On 4/10/2014 at 9:11 a.m., Resident #21 was observed sitting with her eyes closed in her wheelchair in the center of her room. Her call light was observed to be on the floor at the foot of her bed and covered by the privacy curtain. In a separate observation at 2:40 p.m., Resident #21 was observed sitting with her eyes closed in her wheelchair several feet away from her bed. Her call light was observed to be lying across her bed, 3-4 feet to the right of Resident #21's reach. CNA #4 was interviewed on 4/10/2014 at 2:55 p.m. regarding how Resident #21 alerts staff when she requires assistance. CNA #4 indicated, "[Resident #21] comes and gets you...she'll chase you down the hall." Resident #21 was observed during multiple, random observations 4/9/2014 through 4/10/2014. She was not observed to self-propel in her wheelchair at any time.</p> <p>On 4/10/14 at 9:11 a.m., Resident #51 was observed in her room, sitting in her wheelchair at the foot of her bed, facing the closet. Her call light was observed wrapped around the right grab bar at the head of her bed, 2-3 feet behind her. During a separate observation at 2:40 p.m., Resident #51 was observed in her room, sitting in her wheelchair next to the foot of her bed and facing the head of her bed. Her call light was observed near the head of the bed, lying across the bed towards the opposite side, 4-5 feet out of Resident #51's reach. She indicated, "Can you help me get into bed? I</p>		<p>deficient practice. DHS or Designee will conduct an audit of all dependent residents to ensure placement of call lights are within reach.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will in-service staff on proper call light placement and all new staff will be in-serviced during orientation.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit call light placement of 2 residents weekly for 1 month, then monthly for 5 months. Findings will be reported to the QA Committee monthly for review and further recommendations if necessary. (attachment F-246)COMPLETING DATE:5-15-14</p>		

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	<p>don't know what to do. I need help." Resident #51 further indicated that she requires physical assistance to transfer from her wheelchair to her bed. She pointed to the left upper grab bar at the head of her bed and indicated, "That's the only one [call light] I know of." CNA #4 was notified that Resident #51 was requesting assistance. CNA #4 was interviewed at that time regarding how Resident #51 alerts staff when she requires assistance. She indicated, "She usually comes and gets us." Resident #51 was then observed to require a 2-person physical assist to transfer from her wheelchair to her bed.</p> <p>On 4/10/2014 at 10:41 a.m., Activities Associate #3 was observed returning a resident to her room following an activity and was interviewed at that time. She indicated, "I always put the call light right by them. You don't want to leave them helpless in there. Not everyone does [place the call light within residents' reach]." She further indicated that all residents, regardless of their cognition or physical ability to use their call light, should have their call light placed within reach; indicating, "You just never know."</p> <p>The Assistant Director of Nursing (ADoN) was interviewed on 4/10/2014 at 11:10 a.m. She indicated that, unless a resident is independently mobile/ambulatory, each resident should have their call light within reach, regardless of their cognition or physical ability to use it. The ADoN indicated, "They may have family who will use it."</p> <p>"Guidelines for Answering Call Lights" was provided by RN #5 on 4/10/14 at 3:15 p.m. and reviewed at that time. The policy did not indicate any specific direction regarding call</p>						

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F000272 SS=D	<p>lights being placed within reach of residents while in their rooms.</p> <p>During an interview with the Director of Nursing (DoN) and the Administrator on 4/15/2014 at 3:45 p.m., both indicated that all residents who are not independently mobile/ambulatory should have call lights positioned within reach while in their rooms.</p> <p>3.1-3(v)(1) 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment</p>			

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	<p>performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure concerns expressed by residents and noted by nursing staff were thoroughly assessed for 1 or 2 residents reviewed for dental status and 1 of 3 resident reviewed for limited range of motion of lower extremity in a sample of 35. (Resident #s 64 and 106)</p> <p>Findings include:</p> <p>1. Interview with Resident #64, on 4/8/14 at 10:45 a.m., indicated she had tooth problems which made it difficult to eat. She indicated she needed her lower teeth removed and had seen an oral surgeon regarding the extractions. Observation at the time, the resident pointed to her lower teeth which were broken.</p> <p>Resident #64's clinical record was reviewed on 4/10/14 at 10 a.m. A physician's progress note, dated 11/18/13, indicated the oral surgeon had planned to extract nine teeth.</p> <p>The annual and quarterly Minimum Data Set assessments, dated 8/16/13, 11/7/13 and 2/7/14, indicated there was no problem with the resident's teeth.</p> <p>The most recent nutrition assessment, dated 8/6/13, did not indicate the resident had any teeth problems, but noted, "Dentition - own teeth."</p>	F000272	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Resident #64's MDS was updated to reflect current dental status and Resident #106's MDS was updated to reflect their current limitations of range of motion of her lower extremity. 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. DHS or Designee will conduct an audit of the MDS of all residents that have their natural teeth and residents that have limited ROM of their extremities to ensure their MDS is accurate. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: DHS or Designee will re-educate MDS Coordinator to</p>	05/15/2014	

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	<p>During an interview on 4/11/14 at 10 a.m., C.N.A. #1 indicated the resident had top dentures which the C.N.A. rinses. She reported she did not do anything with the resident's lower teeth, but knew she had some teeth problems.</p> <p>During an interview on 4/11/14 at 11 a.m., the Regional Nurse indicated the MDS was inaccurate because the resident does have problems with her teeth and there was no care plan.</p> <p>2. Interview with the Unit Manager of the 100 hall, on 4/8/14 at 2:00 p.m., indicated Resident #106 had a contracture, defined as a condition of fixed high resistance to passive stretch of a muscle, of her right hip and knee and did not received range of motion services.</p> <p>Interview with the resident, on 4/10/14 at 8:46 a.m., indicated she had stiffness of her left hip and knee and touched both. She said both were stiff and sore. She indicated she did not exercise her left leg much because she forgot. She indicated no staff comes in to exercise her legs, but she would welcome it.</p> <p>Record review, on 4/10/14 at 9 a.m., indicated the Minimum Data Set (MDS) assessments, dated 8/13, 11/13 and 2/14, indicated there was no limitation of ROM and no impairment of the lower extremities.</p> <p>Interview with the nurse who completes the MDS on 4/10/14 at 10 am, indicated she checks the residents, but did not document it anywhere. She reported she takes what she reads in the nurses notes and C.N.A. information to complete the assessments.</p>		<p>ensure MDS assessments are accurate. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit one MDS per week for accuracy for 2 months, then monthly for 4 months. Findings will bereported to the QA Committee each month for review and further recommendations if necessary. (attachment F-272)COMPLETING DATE:5-15-14</p>		

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F000279 SS=D	<p>Interview with the DON, at 11:21 am on 4/11/14, indicated there was not further assessment for the resident's range of motion.</p> <p>3.1-31(b)(3) 3.1-31(b)(9) 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 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 record review and interview the facility failed to develop a comprehensive care plan for a resident who received a drug requiring daily monitoring and routine laboratory testing for one of five residents reviewed for medications. (Resident #9)</p> <p>Findings include:</p>	F000279	CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Resident #9's Care Plan was	05/15/2014

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	<p>Resident #9's record was reviewed on 4/10/14 at 10:45 a.m. and indicated on the Minimum Data Set (MDS) the resident received an anticoagulant daily for atrial fibrillation since admission, 10/31/13. The resident had several laboratory tests and physician order changes regarding the coumadin use since admission. There was no plan of care for the use of the anticoagulant.</p> <p>Interview with the DON (Director of Nursing), on 4/11/14 at 2 p.m., indicated there was no care plan for the anticoagulant.</p> <p>3.1-35(a)</p>		<p>updated to reflect her coumadin usage. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents receiving medication that requires daily monitoring and routine lab testing have the potential to be affected by the same alleged deficient practice. DHS or Designee will review the Care Plans of all residents receiving Coumadin to ensure they are being monitored daily and lab tests are done routinely.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will re-educate MDS Coordinator and Nursing Unit Managers on entering anticoagulant Care Plans for Residents receiving anticoagulant medications.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit Residents receiving Coumadin monthly for 6 months. Findings will be reported to the QA Committee for review and further recommendations if necessary. (attachment F-279).COMPLETION DATE:5-15-14</p>	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to provide end-of-life services which recognized and thoroughly addressed the physical needs for one resident reviewed for receiving end-of-life services, resulting in on-going, unrelieved pain. This deficient practice affected 1 of 7 residents in the facility receiving end-of-life services. (Resident #92)</p> <p>Findings include:</p> <p>During an interview on 4/9/2014 at 11:30 a.m., Resident #92 indicated he had unrelieved pain from mouth cancer and was receiving Hospice services. Resident #92 placed the palm of his hand over his left cheek and jaw to indicate the location of the pain.</p> <p>Resident #92's clinical record was reviewed on 4/9/2014 at 3:00 p.m. Diagnoses included but were not limited to mouth and throat cancer, atrial fibrillation, and chronic obstructive pulmonary disease. His BIMS (Brief interview for mental status) was 15, indicating no cognitive impairment.</p> <p>During an interview on 4/9/2014 at 3:30 p.m., LPN #7 indicated the Hospice nurse made a</p>	F000309	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:There were no adverse outcomes to any residents as a result of the alleged deficient practice. Resident #92's Pain Status will be controlled and addressed by the physician. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents receiving end of life services have the potential to be affected by the same alleged deficient practice. DHS or Designee will review all Residents receiving end of life services to ensure their pain is being controlled.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will in-service nurses on pain management of Residents</p>	05/15/2014			

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	<p>visit on Monday 4/7/2014 and wrote a new order for "Fentanyl trans-dermal patch 100 micrograms (mcg) to be changed every 48 hours. Roxanol 20 milligrams (mg) by mouth (Po) every two hours routinely while awake. Percocet 7.5/325 mg every four hours as needed for pain."</p> <p>On 4/10/2014 at 10:00 a.m. record review indicated LPN #7 phoned the Hospice nurse on 4/9/14 at 5:00 p.m. and informed her that Resident #92 was still having pain. LPN #7 requested a long-acting pain medication because the resident did not have much fat tissue to absorb the medication from the fentanyl patch. As of time of record review, no new orders were received.</p> <p>During an interview on 4/11/2014 at 10:40 a.m., Resident #92 indicated he was still having pain. The dosage and frequency change of the fentanyl patch had made no difference in his pain. The Hospice nurse was scheduled to make a visit on this date. Resident #92 indicated he was awakened every two hours through the night to take oral pain medication.</p> <p>Resident #92's current Medication Administration Record (MAR) was reviewed on 4/11/2014 at 10:47 a.m. The dates 4/1/2014 through 4/11/2014 indicated that Resident #92 was administered Roxanol 20 mg at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. The medication order indicated "Roxanol 20 mg per milliliter (ml) solution, give 1 ml (20 mg) Po every two hours while awake."</p> <p>During an interview on 4/11/2014 at 11:03 a.m., the Director of Nursing (DoN) indicated that facility nurses had made several phone</p>		<p>receiving end of life care, and if Resident's pain is not managed by Hospice Services to report to the DHS or Designee to have Medical Director to follow up.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will interview/assess one Resident receiving end of life care each week for 1 month, then monthly for 5 months. Findings will be reported to the QA Committee each month for review and further recommendations if necessary. (attachment F-309).COMPLETION DATE:5-15-14</p>				

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F000318 SS=D	<p>calls to the Hospice nurse concerning Resident #92's continued pain and the resident had not been pain free.</p> <p>On 4/11/2014 at 2:35 p.m., the DoN indicated the Hospice nurse was notified on 4/10/14 of Resident #92's pain and a new order for "prednisone 10 mg Po (by mouth) daily for 10 days" was received. The Hospice nurse indicated the Hospice Medical Director did not want to start any other medications until he knew if the prednisone was helping.</p> <p>3.1-37(a) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review and interview the facility failed to provide range of motion services to maintain the resident's functional status for one of one resident reviewed for range of motion services. (Resident #106)</p> <p>Findings include:</p> <p>1. Interview with the Unit Manager of the 100 hall, on 4/8/14 at 2:00 p.m., indicated Resident #106 had a contracture, defined as a condition of fixed high resistance to passive stretch of a muscle, of her right hip and knee and did not received range of motion services.</p>	F000318	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Resident #106 will have a ROM Assessment completed and a Care Plan developed that addresses her limited ROM.</p> <p>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS</p>	05/15/2014

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	<p>Interview with the resident, on 4/10/14 at 8:46 a.m., indicated she had stiffness of her left hip and knee and touched both. She said both were stiff and sore. She indicated she did not exercise her left leg much because she forgot. She indicated no staff came into exercise her legs, but she would welcome it. The resident indicated she had therapy when she was first admitted, but it was only for the upper body.</p> <p>Record review, on 4/10/14 at 9 a.m., of the Minimum Data Set (MDS) assessments, dated 8/13, 11/13 and 2/14, indicated there was no limitation of ROM and no impairment of the lower extremities.</p> <p>Interview with the nurse who completes the MDS, on 4/10/14 at 10 am, indicated she checks the residents, but did not document it anywhere. She reported she takes what she reads in the nurses notes and C.N.A. information to complete the assessments.</p> <p>Interview with the DON (Director of Nursing), at 11:21 a.m. on 4/11/14, indicated the resident had a stroke and was flaccid on the right side. She indicated there had not been an assessment of the resident's range of motion.</p> <p>Record Review, on 4/10/14 at 9 a.m., indicated there was no plan of care regarding range of motion.</p> <p>Interview with C.N.A. #1, on 4/11/14 at 10:05 a.m., indicated the resident's left leg can bend, but the other is just dead weight. When asked if range of motion was provided to the resident, she indicated the resident's leg was moved when getting ready for the day, but no range of motion was provided.</p>		<p>TAKEN:All residents having limited ROM have the potential to be affected by the same alleged deficient practice. DHS or Designee will review the medical records of Residents with limited ROM to ensure that treatment plans are in place and Care Plans are developed. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will in-service nurses to identify Residents with limited ROM and to develop a treatment plan.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit 1 chart each week for 1 month, thn 1 chart each month for 5 months. Findings will be reported to the QA Committee for review and further recommendations if necessary. (attachment F-318).COMPLETION DATE:5-15-14</p>	

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F000329 SS=D	<p>3.1-42(a)(2) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents on antipsychotic drugs had gradual dose reductions or documentation to support the residents' continual need for the drugs for 2 of 5 residents reviewed for medication use. (Residents # 91 and 75)</p> <p>Findings include:</p> <p>1. Resident 91's clinical record was reviewed on 4/9/14 at 3 p.m. and indicated the resident</p>	F000329	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: There were no adverse outcomes to any residents as a result of the alleged deficient practice. Resident #75 and #91's MD will be notified to request a gradual dose reduction of their antipsychotic medication.</p> <p>IDENTIFICATION OF OTHER</p>	05/15/2014

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	<p>received Seroquel and Haldol for behaviors. The resident had diagnoses including, but limited to, dementia with severe disturbance of behavior and mood.</p> <p>The Minimum Data Set (MDS) assessments, dated November 2013 and February 2014, indicated the resident had no behavior problems.</p> <p>The plan of care indicated the mood monitoring form was stopped on 9/17/13 due to no noted issues and started on 10/4/13 for wandering and stopped on 10/7/13. The plan of care indicated the resident had one instance of verbal and physical aggression with her roommate on 3/5/14.</p> <p>Interview with the social service staff, on 4/9/14 at 3:20 p.m., indicated the facility did not change the resident's medications because the resident's verbal and physical aggression was much worse when she came to the facility 3.5 years ago. Additionally, they do not monitor the resident weekly any longer because she did not have any behaviors.</p> <p>The physician was asked to reduce Haldol on 12/13/13 and an "x" was placed in a box to indicate the reduction was contraindicated. There was no documentation to indicate when the last reduction was or why the reduction was contraindicated. On 1/24/14, the physician was asked about reducing Seroquel, a second psychotropic drug. The physician noted, "Due to agitation and behaviors, dose reduction is not recommended."</p> <p>Observation of the resident, on 4/9/14 at 2:55 p.m., indicated the resident was sitting in her room in the wheelchair with her eyes closed.</p>		<p>RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents receiving antipsychotic medication have the potential to be affected by the same alleged deficient practice. DHS or Designee will review the medical records of all Residents receiving antipsychotic medications to ensure they have had a gradual dose reduction unless clinically contraindicated with supportive documentation.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Executive Director, DHS or Designee will in-service interdisciplinary team on Gradual Dose Reduction guidelines.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or Designee will audit the medical record of one resident receiving antipsychotic medications each month for 6 months. Findings will be reported to the QA Committee for review and further recommendations if necessary. (attachment F-329).COMPLETION DATE:5-15-14</p>				

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	<p>Observation of the resident, on 4/10/14 from 8:15 a.m. through 9:06 a.m., indicated the resident was sitting in a wheel chair outside her room. She was asleep with her head hanging down during this time frame. At 10:29 a.m., she was in her room in her wheel chair sitting directly beside her roommate. The resident had her eyes closed and her head hanging down. The resident's roommate had lifted the half tray on her wheel chair and had rested it on the resident's shoulder. This was brought to the attention of nursing staff and the tray was removed from Resident 91's shoulder.</p> <p>Observation of the resident at, 12 noon on 4/10/14, indicated the resident was sitting in the Restorative dining room. The resident continued to sit with her head down. She responded when staff cued her to eat.</p> <p>Interview with the DON (Director of Nursing), on 4/11/14 at 2 p.m., indicated the resident has been much more sleepy than usual for her the present week. The DON had noted the resident's drowsiness.</p> <p>2. The clinical record for Resident # 75 was reviewed, on 4/10/14 at 2:45 p.m., and indicated the resident had diagnosis, including but not limited to, organic mental syndrome.</p> <p>The resident received an antipsychotic drug, Zyprexa, daily. The Minimum Data Set assessments, dated 11/27/13 and 1/22/14, indicated the resident had no cognitive impairment, and no mood or behavior problems.</p> <p>The resident was observed at lunch, on</p>			

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  04/15/2014	
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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F000371 SS=F	<p>4/10/14 at 11:49 a.m., and was awake and alert and drinking coffee unassisted. She sat at a table with other female residents in the main dining room.</p> <p>A 3/22/13 Gradual dose reduction request for Zyprexa was denied, and the following was checked: "Do not attempt to taper the dose of this drug. In my professional opinion, and /or by diagnosis, to do so is clinically contraindicated. [By definition, clinically contraindicated means that the resident has an approved indication for use and /or has had a gradual dosage reduction and the dose has been reduced to the lowest possible dose necessary to maintain the resident's functional status]."</p> <p>Social Service note for 1/16 -1/22/14 indicated there were no mood or behavior problems and the resident had been on Zyprexa since admission February 2012.</p> <p>3.1-48(a)(2) 3.1-48(b)(2) 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 and interview, the facility failed to ensure the kitchen was kept clean and staff were knowledgeable regarding hand washing for two of two observations.</p>	F000371	CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:There were no adverse outcomes to any residents as a result of the	05/15/2014			

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	<p>Findings include:</p> <p>1. Observation of the kitchen upon entrance to the facility, on 4/7/14 at 9:45 a.m., the kitchen floor was dirty with paper trash, food bits and dirt. Breakfast clean up was in progress.</p> <p>2. Observation of the kitchen, on 4/10/14 at 3:20 p.m., the floor to the kitchen was dirty with paper trash, food items, crumbs, grime. The floor to the dry storage area was also dirty with white powder, dust and grime.</p> <p>Three dietary staff were in the kitchen. They indicated staff needed to wash hands for 10 - 20 seconds.</p> <p>The Food Service Director (FSD) entered the kitchen at 3:50 pm. There was a sign over the hand sink that indicated hands should be washed for 10 - 15 seconds. The FSD indicated he had not noticed it did not indicate the required 20 second hand wash.</p> <p>Interview with the FSD indicated the kitchen was dry mopped after every meal, indicating the kitchen had just been mopped at 1 p.m.</p> <p>The stainless mixer in a stand was dirty with dried-on spills and white powder. The shelf it set on was dirty, as well as the bottom shelf that held three different mixer attachments, uncovered.</p> <p>A cart was positioned beside the grill and was covered with a white towel. The towel was dirty. On top of the towel were plates, a spatula and an unlabeled bottle of a liquid substance. The FSD indicated it was liquid butter.</p>		<p>alleged deficient practice. No Residents were affected.</p> <p>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. Dietary staff was in-serviced on proper handwashing and introduced to new cleaning schedules.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Director of Food Services or Designee will in-service the dietary staff on proper handwashing guidelines and in-service them on new cleaning schedules.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Director of Food Services or Designee will observe staff for adherence to handwashing guidelines 2 times per week for 1 month, then monthly for 5 months. Dietary Support will conduct Sanitation Audits monthly for 6 months. Findings will be reported to the QA Committee for review and further recommendations if necessary. (attachment</p>		

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R000000	<p>The hood to the ovens, grills and fryer was dirty with grease. The FSD indicated the hood was cleaned quarterly and was last cleaned in January.</p> <p>There was a buildup of grease on the sides of the fryer, steamer and ovens. The insides of the double oven were dirty with baked-on food debris.</p> <p>The two shelves holding spices were five foot long and were dirty.</p> <p>The tray carts used to carry food trays to the units were in the catering room. They were both dirty on the inside with dried food debris.</p> <p>3.1-21(i)(3)</p> <p>Silver Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R000000	<p>F-371).COMPLETION DATE:5-15-14</p> <p>Silver Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>				