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 05/24/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00107573. Complaint IN00107573 Substantiated - Federal/State deficiencies related to allegation are cited at F157, F241 and F309. Unrelated deficiency cited. Survey dates: May 23 & 24, 2012 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Survey team: Leslie Parrett RN, TC Barbara Gray RN Census bed type: SNF/NF: 47 SNF: 26 Residential: 33 Total: 106 Census payor type: Medicare: 26 Medicaid: 17 Other: 63 Total: 106	F0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 11 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/1/12 by Jennie Bartelt, RN.			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, interview, and record review, the facility failed to notify the physician and the resident's family timely, of a resident who had sustained a large bruise on her right elbow, for 1 of 7	F0157	1.) Bruise on Resident E has healed. Geri-sleeves were applied.2.) DHS or Designee will inservice hospice aides to fill out shower sheets and to notify nurse with any new areas of concern.3.)	06/23/2012

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	residents sampled for bruises, in the total sample of 11. (Resident #E) Findings include: Resident #E was observed seated in her wheelchair in her bedroom on 5/23/12 at 7:20 P.M. A large purple bruise approximately 3 inches in diameter was observed on her right elbow. Resident #E's record was reviewed on 5/23/12 at 5:52 P.M. Diagnoses included but were not limited to Alzheimer's dementia, peripheral vascular disease, and anxiety. Resident #E's significant change Minimum Data Set assessment dated 2/29/12, indicated she was rarely able to understand and rarely understood others. Her cognitive skills for daily decision making were severely impaired. She required extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, personal hygiene, and she did not walk. A Potential Alteration in Skin Integrity Care Plan for Resident #E initiated 9/22/08 and scheduled for review on 6/4/12, indicated the following: Problem-Potential for alteration in skin integrity related to immobility,		DHS or Designee will inservice Nursing Staff on Family and Physician notification.4.) Weekly skin sweeps to be completed by nursing weekly x 4 then monthly x 4.5.) Notification and skin sweeps to be monitored through QA monthly.	

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	incontinence, and normal progression of disease process with an unavoidable, predictable decline expected. Interventions-Assess/record changes in skin status. Report pertinent changes in skin status to physician. Collaborate with hospice on changes. No assessment or documentation was available in Resident #E's record related to the large bruise on her right elbow. An interview with RN #1 on 5/24/12 at 6:15 P.M., indicated she did the skin assessments on Resident #E's hall, and she wasn't aware of the large bruise on Resident #E's right elbow. RN #1 indicated she investigated Resident #E's right elbow bruise late in the evening on 5/23/12, after it was brought to her attention. An Other Skin Impairment Assessment for Resident #E dated 5/23/12, provided by RN #1 on 5/24/12 at 6:20 P.M., indicated the following: Right elbow bruise. 9.5 centimeters (cm) in length by 7.1 cm in width. Physician and family were notified. A nurses note for Resident #E, dated 5/24/12 at 7:00 A.M., indicated the following: Resident #E's physician and family were notified of Resident #E's			

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	bruise on her right elbow. A Physician Notification Guidelines policy provided by RN #2 on 5/24/12 at 7:15 P.M., indicated the following. "Purpose-To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure-1.) Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner". 2.) The physician should be notified of critical lab results or an immediate need by phone as soon as the results are known with a response received before the call is completed when possible. If the physician must be paged a call back is expected within 15 minutes to one hour depending on severity of the concern. 3.) All other test results or order requests may be faxed to the physician's office during office hours".... This federal tag relates to Complaint IN00107573. 3.1-5(a)(2)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to feed residents in a dignified manner, in that staff was observed standing while feeding residents, for 3 of 3 residents who required assistance with meals, in the total sample of 11, in 1 of 3 dining rooms observed. (Residents #E, #J, and #K). Findings include: An observation of the evening meal was conducted on 5/23/12 at 5:22 P.M., in the Health Care Assisted dining room. Residents #E, #J, and #K were seated at the same dining table. All three residents received total assistance with their meals. CNA #3 was seated on a rolling stool between Residents #E and #J. CNA #3 was observed serving food and drink intermittently to both of these residents. CNA #3 periodically rose from the stool and walked around Resident #E to Resident #K and served Resident #K food and drink. CNA #3 stood when she fed Resident #K. CNA #3 would walk back and stand between Resident #E and	F0241	1.) Inservice Nursing Staff related to Resident dignity related to meal service.2.) Inservice Nursing Staff to sit while feeding residents, and to feed only 2 residents at a time. 3.) Meal Managers to monitor Restorative Dining Room during Meal Service to ensure compliance daily x 2 weeks, 3 x week for 2 weeks, weekly x 2 weeks, monthly x 2 months. 4.) Compliance will be monitored through QA process.	06/23/2012

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	Resident #J and offer food and drinks while standing. CNA #3 sat down periodically on the stool while she assisted Residents #E and #J. This procedure was observed the entire meal including the three residents being fed their desserts. An interview with CNA #3 on 5/23/12 at 7:37 P.M., indicated she usually only fed two residents at a time and would sit between them. CNA #3 indicated she knew she should sit down when she fed residents. This federal tag relates to Complaint IN00107573. 3.1-3(t)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to assess, document, and notify the physician and resident's family, of a resident who had sustained a large bruise on her right elbow, for 1 of 7 residents sampled for bruises, in the total sample of 11. (Resident #E) Findings include: Resident #E was observed seated in her wheelchair in her bedroom on 5/23/12 at 7:20 P.M. A large purple bruise approximately 3 inches in diameter was observed on her right elbow. Resident #E's record was reviewed on 5/23/12 at 5:52 P.M. Diagnoses included but were not limited to Alzheimer's dementia, peripheral vascular disease, and anxiety. Resident #E's significant change Minimum Data Set assessment dated 2/29/12, indicated she was rarely able to	F0309	1.) Bruise on Resident E has healed. Geri-sleeves were applied.2.) DHS or Designee will inservice hospice aides to fill out shower sheets and to notify nurse with any new areas of concern.3.) DHS or Designee will inservice Nursing Staff on Family and Physician notification.4.) Weekly skin sweeps to be completed by nursing weekly x 4 then monthly x 4.5.) Notification and skin sweeps to be monitored through QA monthly.	06/23/2012

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	understand and rarely understood others. Her cognitive skills for daily decision making were severely impaired. She required extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, personal hygiene, and she did not walk. A Potential Alteration in Skin Integrity Care Plan for Resident #E initiated 9/22/08 and scheduled for review on 6/4/12, indicated the following: Problem-Potential for alteration in skin integrity related to immobility, incontinence, and normal progression of disease process with an unavoidable, predictable decline expected. Interventions-Assess/record changes in skin status. Report pertinent changes in skin status to physician. Collaborate with hospice on changes. No assessment or documentation was available in Resident #E's record related to the large bruise on her right elbow. An interview with RN #1 on 5/24/12 at 6:15 P.M., indicated she did the skin assessments on Resident #E's hall and wasn't aware of the large bruise on Resident #E's right elbow. RN #1 indicated she did not know why an assessment was not completed, concerning the large bruise on Resident			

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	#E's right elbow. RN #1 indicated she investigated Resident #E's right elbow bruise late in the evening on 5/23/12, after it was brought to her attention. RN #1 indicated she had spoken with the hospice nurse and was informed the hospice nurse and a facility nurse had transferred Resident #E into bed on 5/15/12, and Resident #E had accidentally hit her right elbow on her bed siderail. RN#1 indicated the hospice nurse had informed her there was no visible sign of injury at that time. RN #1 indicated she believed that is where the large bruise on Resident #E's right elbow came from. An Other Skin Impairment Assessment for Resident #E dated 5/23/12, provided by RN #1 on 5/24/12 at 6:20 P.M., indicated the following: Right elbow bruise. 9.5 centimeters (cm) in length by 7.1 cm in width. Physician and family were notified. Nurses notes for Resident #E indicated the following: 5/24/12 at 7:00 A.M.- After investigation of a bruise to Resident #E's right elbow, it was found that on 5/15/12, a facility nurse assisted a hospice nurse to transfer Resident #E from her wheelchair to her bed. Staff had transferred the resident using a maxi-lift. When Resident #E was being lowered into bed, her right elbow bumped the			

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	siderail. During the investigation, staff reported, at the time of the incident, Resident #E had denied pain or discomfort and there were no signs or symptoms of redness or bruising. 5/24/12 at 7:00 A.M.-Resident #E's physician and family were notified of Resident #E's bruise on her right elbow. 5/24/12 at 7:30 A.M.-Staff were to ensure Resident #E's siderails were down when she was lowered into bed as an intervention. The Other Skin Assessment Guidelines policy provided by RN #2 on 5/24/12 at 7:15 P.M., indicated the following: "Purpose-Utilized to describe and monitor the healing process of skin impairments other than pressure or stasis ulcers. Procedure-1.) This two sided document is completed in black ink by an RN/LPN and is a part of the resident's permanent record. a). Complete one form for each impaired area. b.) All measurements are recorded in centimeters. c.) While active, the form may be placed in the TAR, a Skincare book or other designated area. d.) When the form is full, place in the Assessment section of the resident's clinical record. e.) When an area is resolved place in the residents overflow file. 2.) Initiate the form when an area of impairment, (e.g.; skin tear, rash, excoriation, abrasion, burn, cut, open lesion, bruise and/or surgical wound) is			

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	identified. 3.) Complete the section titled "Initial Identification" in its entirety. 4.) Mark the corresponding area on the anatomical figure to identify the location. 5.) Document description of wound using the Documentation Key. 6.) Document objective information about pain. 7.) Enter signature in designated area. 8.) Update the form weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed. 9.) Ensure each section is signed with signature and title of the nurse completing the form. 10.) Note "healed" when the wound no longer requires treatment and monitoring, 11.) Completed forms should be filed in the medical record for three months then moved to the overflow chart". A Physician Notification Guidelines policy provided by RN #2 on 5/24/12 at 7:15 P.M., indicated the following. "Purpose-To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure-1.) Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner". 2.) The			

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	physician should be notified of critical lab results or an immediate need by phone as soon as the results are known with a response received before the call is completed when possible. If the physician must be paged a call back is expected within 15 minutes to one hour depending on severity of the concern. 3.) All other test results or order requests may be faxed to the physician's office during office hours...." This federal tag relates to Complaint IN00107573. 3.1-37(a)			

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F9999	STATE FINDINGS 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144 of the division. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure an unusual	F9999	1.) Inservice All Staff on State Guidelines for Reportable Events.2.) Executive Director to review all Incident and Accident reports for reportable.3. To be monitored monthly x 4 months in QA for compliance.	06/23/2012

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	occurrence that resulted in death was reported to the state agency for 1 of 2 unusual occurrences reviewed. Findings include: An investigation provided by the Executive Director (ED) on 5/24/12 at 3:00 P.M., indicated the following statement documentation from the Director of Health Services (DHS) on 5/17/12: The DHS had received a phone call from LPN #5 on 5/16/12 at 11:19 P.M. LPN #5 indicated RN #4 was down on the floor in the Transitional Care Services (TCS) bathroom and her face was blue. The DHS notified the ED and they both proceeded to the facility. Upon their arrival the ambulance had already left with RN #4. A detective was still on site. The DHS and ED were notified RN #4 had been nonresponsive and had no pulse or respirations when she was found on the bathroom floor, and CPR had been initiated. LPN #5 had informed the DHS and ED that RN #4 was found lying on the floor with her scrub pants partially down and a 10cc syringe with an 18 gauge needle (closed) in the bathroom sink. The ED had searched the bathroom including the trash and found only paper towels. QMA #6 informed the DHS and ED the medication keys were in her possession that night and she had talked			

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	to RN #4 around 10:35 P.M., and RN #4 seemed fine. The DHS and ED counted the narcotic medications and all narcotics were accounted for. The DHS and ED checked the Pyxis and discovered RN #4 had removed 2 percocets at 10:27 P.M., for Resident #L. Resident #L's record was reviewed on 5/24/12 at 3:45 P.M. No documentation was available in Resident #L's records he had received the 2 percocet medications removed from the Pyxis by RN #4 the evening of 5/16/12. An interview with the ED on 5/24/12 at 3:00 P.M., indicated she had received a phone call on 5/16/12 at approximately 11:30 P.M., from the DHS. The DHS informed her that RN #4 had been found in the facility on the TCS employee bathroom floor unresponsive. When the ED arrived at the facility, she was informed RN #4 had been transferred to a local hospital. RN #4 later died at the local hospital. The ED indicated she had not reported the unusual occurrence to the State Agency "because it didn't affect any of the residents". The ED indicated her investigation was not completed because she had not received the toxicology report yet. The Reportable Event Procedural			

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	Guidelines provided by the ED on 5/24/12 at 4:45 P.M., indicated the following: "Purpose: To provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines. Procedure-f.) Unusual or suspicious death...." 3.1-13(g)(1)			