

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 2, 3, 4, 7, 8, 9, 10,2013</p> <p>Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690</p> <p>Survey Team: Carole McDaniel RN TC Martha Saul RN Terri Walters RN</p> <p>Census Bed Type: SNF: 26 SNF/NF: 52 Residential: 17 Total: 95</p> <p>Census Payor Type: Medicare: 21 Medicaid: 43 Other: 31 Total: 95</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect State Findings in accordance with 410 IAC 16.2.</p>	F0000		
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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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	Quality review completed on January 14, 2013, by Jodi Meyer, RN			

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F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents did not self administer drugs without capability and physician order for 1 of 1 randomly observed resident, following medication distribution. Resident #36</p> <p>Findings include:</p> <p>On 1/3/13 at 9:25 A.M., Resident #36 was observed to be in her wheel chair in her room. She was on the side of her room which was occupied by her sleeping roommate, searching around. The resident indicated she was trying to find a spoon. She stated "I have to get this medicine taken. She was holding a 4 ounce plastic cup with approximately 2 ounces of ice cold solid orange matter with approximately a tablespoon of dry tan powder in the bottom of the cup. Her water pitcher was located out of reach. In the hall QMA #1 was standing parked by her medication cart preparing medication for another resident. She identified the orange matter as a packet of</p>	F0176	<p>F176Resident #36 suffered no ill effects from the alleged deficient practice and through corrective action and in-servicing will ensure residents that self administer medication have a physician's order and have been deemed appropriate to do so by the interdisciplinary team. Completion date 2-9-13All residents that self administer have the potential to be affected and therefore have been assessed by interdisciplinary team to ensure they are safe to do so and through education/in-servicing will ensure that residents are reviewed by the team prior to be allowed to do so. Completion Date 2-9-13Systemic change will include interdisciplinary team education/in-service on interpretive guidelines as it relates to self administering medication. Completion Date 2-9-13DHS/Designee will ensure that residents are assessed by interdisciplinary team when order is received to self administer medication and quarterly thereafter or with any significant changes. Completion Date 2-9-13A list of those that self administer their medications and the current assessment will be</p>	02/09/2013			

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	<p>Psyllium powder (bulk forming laxative) mixed with "some water" which she had left with the resident. She provided a packet of the Psyllium from the resident's supply. The manufacturer's label directed to mix with 8 ounces of liquid. QMA #1 indicated she should have used a big (8 ounce) cup rather than the smaller one, should have mixed powder thoroughly, and should have stayed with the resident to assist and ensure it was taken.</p> <p>The clinical record of Resident #36 was reviewed on 1/3/13 at 10:00 A.M. There was a physician order of 5/29/12 for the daily packet of Psyllium to be administered. The resident record lacked an evaluation with determination of reliability to self administer and a self administration order.</p> <p>On 1/10/13 at 9:00 A.M. the "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES", dated 2/1/10, was provided for review by the Director of Nursing. She indicated this was the facility policy and procedure in place.</p> <p>Section C of the policy directed "Administer medication and remain with the resident while medication is</p>		submitted to QA committee monthly for 12 months for review and further recommendations.		

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	<p>swallowed." Section D of the policy directed "Follow all medications with 4 to 8 ounces of water."</p> <p>The reference book "Nursing Spectrum Drug Handbook 2010" by P. Schull and published by McGraw Hill, addressed psyllium. The administration portion of the direction included, "Mix powder with 8 ounces of cold liquid...Give diluted drug immediately after mixing before it congeals. Follow with another glass of fluid.</p> <p>3.1-11(a)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents care plans were consistent with self drug administration assessments and physician orders for 1 of 1 randomly observed resident, following medication distribution. Resident #36</p> <p>Findings include:</p> <p>On 1/3/13 at 9:25 A.M., Resident #36 was observed to be in her wheel chair in her room. She was on the side of her room which was occupied by her sleeping roommate, searching around. The resident indicated she was trying to find a spoon. She stated "I have to get this medicine taken. She was holding a 4 ounce plastic cup with approximately 2 ounces of ice cold solid orange matter with approximately a tablespoon of dry tan powder in the bottom of the cup. Her water pitcher was located out of reach. In the hall QMA #1 was standing parked by her medication cart preparing medication for another resident. She identified</p>	F0282	<p>F282Res #36's careplan has been updated and licensed staff that administer meds to her have been advised of it. Completion Date 2-9-13 All residents determined to be able to self administer meds have had careplans updated to reflect this. Completion Date 2-9-13 Nursing staff will be in-serviced on medication consumption requirement and self administration definition. Completion Date 2-9-13 DHS/Designee will monitor 2 medication passes randomly/daily X 2 weeks, 2 random med passes weekly X 4 and then 2 random med passes monthly to ensure staff are administering all meds to completion unless otherwise indicated on orders to self administer. Audits and list of residents who self administer meds will be forwarded to QA committee monthly for 3 months and quarterly thereafter for review.</p>	02/09/2013			

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	<p>the orange matter as a packet of Psyllium powder (bulk forming laxative) mixed with "some water" which she had left with the resident. She provided a packet of the Psyllium from the resident's supply. The manufacturer's label directed to mix with 8 ounces of liquid. QMA #1 indicated she should have used a big (8 ounce) cup rather than the smaller one, should have mixed powder thoroughly, and should have stayed with the resident to assist and ensure it was taken.</p> <p>The clinical record of Resident #36 was reviewed on 1/3/13 at 10:00 A.M. There was a physician order of 5/29/12 for the daily packet of Psyllium to be administered. The resident record lacked an evaluation resulting in determination of reliability to self administer drugs and a self administration order.</p> <p>The Care Plan of 12/08/12 indicated the resident was to be assisted and/or supervised for activities of daily living however it did not include a plan for self administration of drugs.</p> <p>On 1/10/13 at 9:00 A.M. the "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES", dated 2/1/10, was provided for review</p>						

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	<p>by the Director of Nursing. She indicated this was the facility policy and procedure in place.</p> <p>Section C of the policy directed "Administer medication and remain with the resident while medication is swallowed." Section D of the policy directed "Follow all medications with 4 to 8 ounces of water... Special Considerations included :...Refer to physician order and medication reference text for administration of any medication when added to any substance such as applesauce, juice, milk , etc."</p> <p>The reference book "Nursing Spectrum Drug Handbook 2010" by P. Schull and published by McGraw Hill, addressed psyllium. The administration portion of the direction included, "Mix powder with 8 ounces of cold liquid...Give diluted drug immediately after mixing before it congeals. Follow with another glass of fluid.</p> <p>3.1-35(g)(2)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to ensure preventative measures were in place for the prevention of pressure sore development for 1 of 3 residents who met the criteria for pressure sores. Resident #112</p> <p>Findings include:</p> <p>On 1/9/13 at 11 A.M., the clinical record of Resident #112 was reviewed. The resident was admitted to the facility on 10/29/12. Diagnoses included, but were not limited to, the following: debility, chronic obstructive pulmonary disease, left knee infection (septic arthritis), prostate cancer, hypertension, anxiety, gout, asthma, arthritis, shortness of breath and benign prostatic hypertrophy with urinary retention.</p>	F0314	F 314Resident #112 no longer resides at the campus as stated in the 2567.Completion Date 2-9-13All immobile residents have the potential to be affected by the alleged deficient practice therefore have had skin assessed to ensure interventions and turning/repositioning is in place.Completion Date 2-9-13Through in-services and communication procedures will ensure that turning/repositioning is carried out timely.Completion Date 2-9-13DHS/Designee will conduct daily rounds to ensure that pressure reduction interventions including turning/repositioning is being carried out for a random sample of 5 residents/day X 4 weeks, then 3 residents/day X 4 weeks, and 3/week thereafter.Results of audit as well as full skin report will be forwarded to the QA committee monthly X 12 months and suggestions/recommendations	02/09/2013			

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	<p>The Nursing Admission Assessment, (no date) indicated the following: for mobility and ADLs (activities of daily living) resident was dependent for 2 assist for bed, transfers, wheelchair, ambulation, dressing, bathing and toileting; encourage mobility as able; current infection to left knee; resident does not have a Stage 1 sound (sic) or greater or a scar over a bony prominence; resident is at risk for developing pressure ulcers. The area for Pressure relieving/reducing device to bed and chair was left blank. This form indicated the resident has a history of skin impairment; surgical (sic) to left knee x 3 areas. The portion of this admission nursing assessment for "skin plan of care" was left entirely blank. This area included, but was not limited to, the following: turn and reposition for comfort and with care, prevent skin from touching skin, elevate heels off surface, explain consequences of refusal of treatment and/or prevention interventions; assist with positioning in bed and chair.</p> <p>Nurses notes for 10/29/12 at 7:10 P.M. indicated the following: "...edema to BLE (bilateral lower extremities) with 2+ pitting edema...surgical incisions x 3 to L</p>		carried out as deemed necessary by committee.		

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	<p>(left) knee..."</p> <p>An order, dated 10/30/12, indicated the following: "weekly skin inspection, Sat (Saturday)."</p> <p>The TAR (treatment administration record) date for November 2012 indicated the initial weekly skin inspection was done on 11/4/12.</p> <p>Nurses notes, dated 11/4/12 at 3 P.M., indicated the following: "Noted 7 cm (centimeter) x 5 cm purple pressure area to L heel. Sent COC (change of condition) to (physician name) for skin prep and float heels q (every) shift."</p> <p>A skilled nursing assessment and data collection form dated 11/4/12 at 3 P.M. included but was not limited to, the following: "...CNA (certified nursing assistant) noted purple pressure area (unstageable) to L heel. Skin intact but soft and mushy..." At 10:20 P.M. included, but was not limited to, the following: "+3 edema to BLE..."</p> <p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" form had and initial identification date of 11/4/12. This form indicated the following: area not present on admission;</p>				

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	<p>location of area left heel; pressure ulcer; stage E (non -stageable due to necrotic tissue present); color purple; treatment: skin prep q shift/float heels; length: 7 cm; width: 5 cm. The left heel was measured on the following dates 11/10/12, 11/18/12, 11/24/12: length 7.5 cm and width 5 and depth (blank) with brown exudate, 11/27/12 and 12/1/12. The final measurements on 12/1/12 were length: 4.2 cm, width 4.8 cm and depth 0.1 cm.</p> <p>A care plan, dated 11/6/12, addressed the problem of "potential for alteration in skin integrity." This included, but was not limited to, the following: "...educate resident about primary risk factors, prevention, turn and reposition every two hours...float heels...minimize pressure over bony prominences..."</p> <p>A physician order, dated 11/11/12, indicated the following: "L heel pressure area, cleanse with NS (normal saline)...apply...non-adhesive..."</p> <p>A physician order, dated 11/16/12, indicated the following: "Air speciality mattress."</p> <p>A physician order, dated 11/21/12,</p>				

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	<p>indicated the following: "heel ring to LLE (left lower extremity) when patient in bed..."</p> <p>A physician order, dated 11/21/12, indicated the following: "sharp debridement to L heel wound..."</p> <p>A physical therapy note, dated 12/3/12, 12/5/12 and 12/6/12, indicated the resident was receiving high volt (voltage) e stim (electrical stimulation) to the left heel to promote wound healing.</p> <p>A physician order dated 12/5/12 indicated the resident was discharged home with home health care on 12/7/12.</p> <p>On 1/10/13 at 11:30 A.M., the DON (Director of Nursing) was interviewed. She indicated the Nursing Admission Assessment was completed on the day of admission, 10/29/12. She indicated this form also indicated the resident's risk for pressure sore development. The DON indicated this resident had a pressure reducing mattress upon his admission to the facility. The DON also indicated when a resident is on a pressure reducing mattress, they are still supposed to be turned and repositioned.</p>			

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	<p>On 1/10/13 at 12:55 P.M., the DON provided a current copy of the facility policy and procedure for "General Wound and Skin Care Guidelines." This policy was undated and included, but was not limited to, the following information: "...turn and reposition residents who are immobile according to their care plan requirements...evaluate the need for a pressure reduction surface for bed/chair and the need for...or heel floats...educate residents...on weight shifting in bed/chair and other interventions to prevent skin breakdown...Basic Wound Interventions: "...Evaluate for pressure reduction and/or relief devices for bed/chair, develop and implement turning and/or positioning plan to relieve pressure from affected area(s)..."</p> <p>3.1-40(a)(1)</p>				

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F0323 SS=D	<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 ensure adequate supervision was provided to prevent falls for 2 of 9 residents who met the criteria for falls. Resident # 55, Resident #79</p> <p>Findings include:</p> <p>1. The clinical record of Resident #55 was reviewed on 1/8/13 at 1 P.M. Diagnoses included, but were not limited to, the following: Alzheimers, osteoarthritis, history of hip fracture and history of cerebrovascular disease. The MDS (minimum data set assessment) dated 11/20/12 indicated the following for the resident: total cognition score of 3, which indicated severe cognitive impairment; bed mobility and transferring require extensive assistance; walking in room required limited assistance and balance during transfer and walking was not steady.</p> <p>A care plan with an initial date of 9/7/12, addressed the following</p>	F0323	F323Res # 79 no longer resides at the campus. Res #55 had current fall risks and interventions assessed with staff that care for him in-serviced on his needs. Completion Date 2-9-13 No other residents were affected by the alleged deficient practice and through corrective actions will ensure residents with a history of falls are provided a safe environment and that devices are provided and in use when deemed appropriate. Completion Date 2-9-13 Directed in-service will be provided to nurse managers on fall interventions and alarm usage as well as trends/patterns of falls compared to staffing. Completion Date 2-9-13 DHS/Designee will audit all components of fall documentation with added focus on patterning to ensure compliance with expected standard and risk reduction/repeat falls. Results of monitoring and compliance as well as those residents who have fallen and those who have alarms in use will be forwarded to QA monthly X 12 months.	02/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
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	<p>problem: "Falls, At risk for fall/injury AEB (as evidenced by) history of falls, potential for fall; r/t (related to) disease process/condition of Alzheimer disease, functional problem: requires assist with his transfers, and ambulation..." The goal of this plan of care was "Resident will have reduced risk of fall related injury by utilizing fall precautions."</p> <p>Nurses notes, dated 10/19/12 at 7 P.M. indicated the following: "Resident observed on floor in room. Resident was attempting to transfer himself out of his recliner and slid to floor...Pressure alarm applied to w/c (wheelchair) et (and) bed. Clip alarm applied to recliner..."</p> <p>Nurses notes, dated 11/19/12 at 6:40 P.M., indicated the following: "Resident sitting in w/c in his room. Pressure alarm to w/c. Resident reaching for light to turn off. Fell to floor. CNAs (certified nursing assistants) down hall with a 2 assist resident and could not leave him even though they heard alarm going off. When CNAs came to assist resident, they found him on floor...new intervention to add clip alarm to w/c."</p> <p>A Fall circumstance form, dated</p>			

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	<p>11/19/12, indicated the injury of bruising to right upper arm/forearm and left forearm.</p> <p>Nurses notes, dated 12/22/12 at 4 P.M., indicated the following: Alarm sounding, upon entering room CNAs found client on floor in front of recliner...Intervention: dc (discontinue) clip alarm . Start pressure alarm to chair. Remind client to use call light when he wants to get up. Call light was within reach when he fell, just wasn't used..."</p> <p>Nurses notes, dated 12/28/12 at 2:30 P.M., indicated the following:"Upon skin assessment res (resident) noted to have 11.2 (no measurement identifier documented) x 10.5 (no measurement identifier documented) bruise to l (left) elbow, purple and red in color, 1.4 (sic) x 2.1 cm bruise behind left ear purple in color, 11 (sic) x 12 (sic) bruise to R (right) elbow, purple and red in color..."</p> <p>Nurses notes, dated 1/2/13 at 9:55 A.M., indicated the following: "...noted to have 32.7 (sic) x 16.2 (sic) bruised area from L hand to below L elbow..."</p> <p>On 1/9/13 at 3:25 P.M., the ADON (Assistant Director of Nursing), DON</p>			

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	<p>(Director of Nursing) and Administrator were interviewed. They were made aware of the alarms sounding, the resident fall twice and staff was unable to get to the resident in time to prevent the falls. At this time, no additional information was provided. The DON did indicate the documented bruising in the nurses notes on 12/28/12, was a result of the resident's fall on 12/22/12. She indicated the resident is currently on aspirin.</p> <p>On 1/10/13 at 7:40 A.M., the DON provided a current copy of the facility policy and procedure for "Falls Management Program Guidelines." This policy is dated as revised on 3/08. This policy included, but was not limited to, the following: "Purpose:...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures... Procedure:...a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode..."</p> <p>2. On 1/8/12 at 2 P.M., the clinical record of Resident #79 was reviewed. Diagnoses included but were not limited to, the following: dementia, history of fracture of humerus and</p>			
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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
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	<p>osteoarthritis.</p> <p>A Nursing Admission Assessment and Data Collection, dated 12/11/12 included, but was not limited to, the following for the resident: extensive assist for transfers; cognitive impairment that effects safety/judgement; history of falls; assistance required to ambulate; takes meds (medications) that may affect balance, cognition or gait;</p> <p>Nurses notes, dated 12/16/12, at 12:20 A.M., indicated the following: "Called to room by CNA - res (resident) noted to be laying on floor-partially on mat, laying on L (left) side..Res (resident) stated she was sitting on side of bed et (and) slid off, hitting head. Head noted to be against bed side stand. 5 x 7 cm (centimeter) hematoma noted to L forehead above eye, 4 x 5 cm purple bruising noted to L eye - with some swelling noted extending to cheek bone. Small abrasion noted to the area..."</p> <p>Nurses notes, dated 12/21/12 at 11:45 P.M., indicated the following: "Clip alarm et (and) pressure alarm sounding at this time in res (resident) room. CNAs entered room et found res lying on mat on floor...Res noted</p>				

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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
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	<p>to have hit R posterior head on night stand beside bed. No bleeding noted but res touching area et stating head hurts..."</p> <p>On 1/3/13 at 10:33 A.M., the Resident was observed in her bed. A yellowing bruise was observed to left brow area with goose egg type area in the center.</p> <p>On 1/3/13 at 12:55 P.M., the resident was observed in the dining room. The yellow bruising as observed at 10:33 A.M., extended down from the left brow area, over the left cheek area, back to the left ear and down left side of face to the chin area. The above bruising was yellowish in color.</p> <p>On 1/9/13 at 10:28 A.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were interviewed. The ADON indicated the resident's first fall was on 12/16/12. She indicated the intervention in place after this fall, was to change the bed to an electric hi low bed, with the bed in the lowest position. She indicated they also added a clip alarm. The ADON stated the resident also kept the pressure pad alarm in the bed and she felt better by the resident having</p>				

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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
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	<p>both alarms (clip and pressure). The ADON indicated the resident's next fall was on 12/21/12. She stated the intervention after this fall was to put the resident in a low bed that is closer to the ground. She indicated they also moved the night stand and the resident continued with both the pressure and clip alarms.</p> <p>On 1/9/13 at 11 A.M., it was observed that both Resident #55 and Resident #79 resided on the same hall of the facility.</p> <p>On 1/9/13 at 3:25 P.M., the ADON (Assistant Director of Nursing), DON (Director of Nursing) and Administrator were interviewed. They were made aware of the alarms sounding and staff was unable to get to the resident in time to prevent the fall on 12/21/12. At this time, no additional information was provided. They indicated the resident is currently on aspirin.</p> <p>3.1-45(a)(2)</p>				

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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
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F0467 SS=E	<p>483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.</p> <p>Based on observation, interview and record review, the facility failed to provide adequate ventilation during environmental refurbishment procedures in 3 of 5 resident halls of the Health Care portion of the facility.</p> <p>Findings include:</p> <p>On 1/07/13 at 9:00 A.M., there was a pervasive strong heavy vapor odor building in the front foyer of the facility. The vapors increased in intensity from that vantage point as the observation proceeded toward the Health Care portion of the facility. The main Health Care area consisted of a primary nurses station area under renovation, at the hub/center of 3 halls. A second smaller unit and nurses station was beyond fire doors and not impacted.</p> <p>The source of the most intense fumes was emanating from a staining process being completed on 3 large wooden pillars and a wall in the lounge of the hub area. There were 2 painters staining with product from an</p>	F0467	<p>F467All residents on the Health Care Unit had the potential to be affected by the alleged deficient practice and through corrective measures such staff in-servicing on the signs/symptoms of respiratory distress along with hourly monitoring of all residents for 7.5 hrs of these sign/symptoms; none were noted to be affected. .Completion Date 1-7-13Systemic change is that all contractors will provide containment/exposure plan prior to beginning work if there are risks or precautions. Maintenance Director/Designee will review plan along with MSDS to ensure proper ventilation is providedCompletion Date 2-9-13Maintenance Director/Designee will collect/inspect all plans submitted and forwarded to ED for Safety/QA committee review monthly.</p>	02/09/2013	

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	<p>unlabeled aluminum paint bucket. When interviewed about the fumes neither painter could provide any identifying data regarding the stain or respiratory hazard protection warnings. Painter #1 indicated they did not have a bucket of stain with a label. He indicated he had been very concerned about the intensity of the fumes so had called "the office" and been instructed to "keep going." After being informed of the concern, the painter indicated he intended to stop the work. The work continued another 10 minutes until the completion of a wall at 9:20 A.M. There was an industrial fan at the head of each hall. Resident room doors were open in all 3 halls. 1 of 3 halls (200 hall) had 1/2 of a fire door closed at the head of the hall. Also working directly in the area of the highest vapor was the facility Director of Plant Operations (DPO).</p> <p>At 9:30 A.M., midway in the center of the 200 hall, the Payroll Director was observed to be fanning the air with a notebook in large sweeping gestures and commenting to other staff and shaking her head from right to left. At the same time RN #1 was observed coming from the 100 wing toward the hub holding her forehead with a pained expression. She indicated</p>			
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	<p>she had a headache and did not know if it had been caused or just irritated by the fumes.</p> <p>At 9:35 A.M. the DPO was interviewed regarding the ventilation problem. He indicated the painters were contract employees from a construction company and the facility did not have a Material Safety Data Sheet (MSDS) for the stain preparation being used. He indicated the facility did not have a plan for prevention of potential environmental hazards during the extensive renovation. He indicated there had not been any specific training or orientation for contracted workers for work performed within an occupied Long Term Care Facility.</p> <p>At 10:00 AM the Administrator, accompanied by the DPO, was informed of the problem. She indicated the facility was aware of the ventilation problem and had responded by trying to keep residents occupied in activities and trying to vent some of it off. At that point the Administrator directed the DPO to terminate the staining, unaware the painters had elected to stop.</p> <p>At 11:00 A.M., the Payroll Director was interviewed regarding her</p>			

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	<p>notebook fanning. She indicated she was trying to clear air around herself as she walked down the 200 hall because she got migraines and had to be careful with very strong odors.</p> <p>The process of removing fumes was observed to markedly improve with windows open over a 45 minute period and by 12:15 P.M. a faint residual odor was left. Nurses were observed to begin checking residents from room to room. Only residents in the rooms furthest from the staining were left remaining in the area.</p> <p>On 1/07/13 at 12:55 P.M., the Operations and Risk Manager from (name) Construction company was interviewed. He indicated the painters had been subcontracted. He provided the MSDS sheet on a product he believed to be what was being used from the unmarked can. The MSDS indicated the product was to be used only with adequate ventilation. It indicated "Local exhaust preferable. General exhaust acceptable if the exposure is maintained below applicable exposure limits...Routes of exposure : Inhalation of vapor or spray mist. Eye and skin contact with the product, vapor or mist...Effects of overexposure which was not extreme</p>			

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	<p>...irritation of the upper respiratory system."</p> <p>On 1/8/13 at 6:15 A.M. Resident #77 was observed sitting at the front door of the facility waving her hand in front of her nose. She stated "Whew that stuff yesterday, boy that was awful..." in reference to the vapors noted above. She denied having trouble breathing but continued repeating "Whew...that was awful..." She indicated it was better after the smell went away. She stated "That smell made me feel yuck."</p> <p>On 1/8/13 at 9:20 A.M., the workmen were observed constructing a wooden frame on which they attached plastic to seal the work area off from the facility. Inside the tent, when work resumed, a large commercial exhaust fan vented fumes up into the attic and no further problems were detected.</p> <p>3.1-19(f)(2)</p>				