

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 03/12/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 5, 6, 7, 10, 11, 12, 2014</p> <p>Facility number: 002512 Provider number: 155671 AIM number: 200278690</p> <p>Survey team: Amy Wininger, RN TC March 5, 6, 7, 10, 11, 12, 2014 Terri Walters, RN Sylvia Martin, RN</p> <p>Census bed type: SNF: 27 SNF/NF: 47 Residential: 23 Total: 97</p> <p>Census payor type: Medicare: 15 Medicaid: 36 Other: 46 Total: 97</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with</p>	F000000		
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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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	<p>410 IAC 16.2</p> <p>Quality review completed on March 13, 2014, by Jodi Meyer, RN</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	F 225			04/11/2014	

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	<p>Based on interview and record review, the facility failed to ensure abuse was reported within the required time frame to State agencies, in that, abuse and/or alleged abuse was not immediately reported to the Indiana State Department of Health and/or the local law enforcement agency immediately within 24 hours for 2 of 3 abuse investigations reviewed. (Resident #98, Resident #117)</p> <p>1. A Communication Result Report provided by the DHS (Director of Health Services) on 03/12/14 at 3:50 P.M., indicated the ISDH (Indiana State Board of Health) was notified on 02/28/14 at 5:08 P.M., an incident of physical abuse had occurred on 02/28/14 at 12:30 P.M., at the facility between a private caregiver and Resident #98. (The ISDH was notified 4 hours and 38 minutes after the incident occurred) An attached incident report further indicated, "...resident...was eating lunch in the dining room accompanied by his private sitter. Facility staff in dining room observed resident...smack private sitter in the stomach and witnessed private sitter say, 'Stop it' and private sitter stood</p>		<p>Resident #98 suffered no ill effects from the findings on the 2567 from the alleged deficient practice.</p> <p>Res #117 suffered no ill effects from the findings on the 2567 from the alleged deficient practice and was found to be just actions within the realm of normal care that was being provided.</p> <p>Although campus believes that the requirement was met by definition of ISDH since there were no injuries, through the implementation of immediately reporting abuse allegations without gathering all necessary information will ensure interpretation of requirement is met. Completion Date 4-11-14</p> <p>ED and DHS will be inserviced on abuse prevention policies and procedures to ensure allegations of abuse are reported immediately before any investigation takes place. Completion Date 4-11-14</p> <p>ED will forward all reportables that are allegations of abuse to supervisor for review and to ensure compliance with immediate requirement.</p> <p>Reportables will be forwarded to QA committee monthly for review of</p>				

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	<p>up and smacked resident on the top of the head with an open hand..." The incident report lacked any documentation the local law enforcement had been notified of the incident.</p> <p>During an interview on 03/12/14 at 4:00 P.M., the DHS indicated the ISDH had been notified of the incident after the initial investigation and follow-up was complete and further indicated, at that time, the local law enforcement agency had not been notified by the facility staff. The DHS further indicated, the private sitter was not allowed to return to the facility and the employing agency of the private sitter would be responsible for any further investigation and/or reporting.</p> <p>2. An undated untimed Incident Report Form provided by the ED (Executive Director) on 03/07/14 at 1:00 P.M., indicated the ED had been notified on 03/06/14 at 3:15 P.M. an anonymous allegation of verbal abuse had been reported. The investigation identified an incident of verbal abuse was alleged between a staff member and Resident #117. The report further</p>		<p>timely reporting x12 months.</p>				

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	<p>indicated the ISDH was notified of the alleged verbal abuse on 03/06/14 at 10:47 P.M. (7 hours 32 minutes after the allegation was initially reported to the ED)</p> <p>During an interview on 03/12/14 at 12:05 P.M., the ED indicated it was his understanding the ISDH was to be notified of abuse and/or alleged abuse within 24 hours of a report of an allegation.</p> <p>The ISDH-Division of Long Term Care Reportable Incidents Policy provided by the ED on 03/12/14 at 12:00 P.M. indicated, "...Procedure: ...The facility must ensure that all alleged violations involving...abuse...are reported immediately..to other officials in accordance with State law...(1) ... Abuse is the willful infliction of injury...intimidation...(A) Physical abuse-includes, but not limited to, hitting, slapping...3.) Other...to resident abuse with or without injury..."</p> <p>The Policy and Procedure for Abuse and Neglect Procedural Guidelines provided by the DHS on 03/11/14 at 2:20 P.M. indicated, "...has developed and implemented processes, which strive to ensure</p>				

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F000226 SS=D	<p>the prevention and reporting of suspected or alleged resident abuse and neglect...g. Reporting...ii...immediately and not more than 24 hours complete an initial report to applicable state agencies...The Elder Justice Act requires that if the event...does not cause result in bodily injury, it must be reported no later that 24 hours..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the abuse policy was implemented, in that, the state agency was not immediately notified and/or local law</p>	F000226	F 226 Resident #98 suffered no ill effects from the findings on the 2567 from the alleged deficient practice. Res #117 suffered no ill effects from the findings on the 2567	04/11/2014			

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	<p>enforcement was not notified of abuse immediately within 24 hours and/or alleged abuse for 2 of 3 abuse investigations reviewed. (Resident #98, Resident #117)</p> <p>1. A Communication Result Report provided by the DHS (Director of Health Services) on 03/12/14 at 3:50 P.M., indicated the ISDH (Indiana State Board of Health) was notified on 02/28/14 at 5:08 P.M., an incident of physical abuse had occurred on 02/28/14 at 12:30 P.M., at the facility between a private caregiver and Resident #98. (The ISDH was notified 4 hours and 38 minutes after the incident occurred) The incident report lacked any documentation the local law enforcement had been notified of the incident.</p> <p>During an interview on 03/12/14 at 4:00 P.M., the DHS indicated the ISDH had been notified of the incident after the initial investigation and follow-up was complete and further indicated, at that time, the local law enforcement agency had not been notified by the facility staff. The DHS further indicated, the private sitter was not allowed to return to the facility and the</p>		<p>from the alleged deficient practice and was found to be just actions within the realm of normal care that was being provided.</p> <p>Although campus believes that the requirement was met by definition of ISDH since there were no injuries, through the implementation of immediately reporting abuse allegations without gathering all necessary information will ensure interpretation of requirement is met. Completion Date 4-11-14</p> <p>ED and DHS will be inserviced on abuse prevention policies and procedures to ensure allegations of abuse are reported immediately before any investigation takes place. Completion Date 4-11-14</p> <p>ED will forward all reportables that are allegations of abuse to supervisor for review and to ensure compliance with immediate requirement.</p> <p>Reportables will be forwarded to QA committee monthly for review of timely reporting x12 months.</p>		

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	<p>employing agency of the private sitter would be responsible for any further investigation and/or reporting.</p> <p>2. An undated untimed Incident Report Form provided by the ED (Executive Director) on 03/07/14 at 1:00 P.M., indicated the ED had been notified on 03/06/14 at 3:15 P.M. an anonymous allegation of verbal abuse had been reported. The investigation identified an incident of verbal abuse was alleged between a staff member and Resident #117. The report further indicated the ISDH was notified of the alleged verbal abuse on 03/06/14 at 10:47 P.M. (7 hours 32 minutes after the allegation was initially reported to the ED)</p> <p>During an interview on 03/12/14 at 12:05 P.M., the ED (Executive Director) indicated it was his understanding the ISDH was to be notified of abuse and/or alleged abuse within 24 hours.</p> <p>The ISDH-Division of Long Term Care Reportable Incidents Policy provided by the ED (Executive Director) on 03/12/14 at 12:00 P.M. indicated, "...Procedure: ...The</p>			

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	<p>facility must ensure that all alleged violations involving...abuse...are reported immediately..to other officials in accordance with State law...(1) ...Abuse is the willful infliction of injury...intimidation...(A) Physical abuse-includes, but not limited to, hitting, slapping...3.) Other...to resident abuse with or without injury..."</p> <p>The Policy and Procedure for Abuse and Neglect Procedural Guidelines provided by the DHS on 03/11/14 at 2:20 P.M. indicated, "...has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...g. Reporting...ii...immediately and not more than 24 hours complete an initial report to applicable state agencies...The Elder Justice Act requires that if the event...does not cause result in bodily injury, it must be reported no later that 24 hours..."</p> <p>3.1-28(a) 3.1-28(c)</p>				

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F000323 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.</p> <p>Based on observation, interview, and record review, the facility failed to identify and implement measures to reduce risk of injury, by not following the manufacturer's instructions for 1 of 1 residents reviewed who utilized an anterior positioning vest. (Resident #37)</p> <p>Findings include:</p> <p>On 3/6/14 at 11:50 A.M., Resident #37 was observed in her wheelchair, with an anterior support vest was in place. She was observed leaning to the right with no seatbelt in place.</p> <p>On 3/7/14 at 9:54 A.M., Resident #37 was observed in her wheelchair, with an anterior support vest in place. She was leaning to her right side with no seat belt in place.</p> <p>3/10/14 at 10:00 A.M. and 11:45</p>	F000323	<p>F 323 Res #37 had anterior support vest discontinued as assessment and choice of campus was to utilize shoulder straps instead for positioning. Resident ability to remove and careplan have been updated to reflect current interventions and all staff that care for her have been inserviced on these. Completion Date 4-11-14</p> <p>There were no other residents affected by the alleged deficient practice and through inservicing will ensure that manufacturer's recommendations are followed for all devices. Completion Date 4-11-14 Nursing and therapy staff inserviced on shoulder straps in use for res#37. Completion Date 4-11-14</p> <p>DHS/Designee will ensure all manufacturer's recommendations are on hand, reviewed and followed for all positioning devices and will monitor 1 device daily x2 weeks, then 2 per week x2 weeks, and 2 monthly thereafter for proper application. Results of</p>	04/11/2014			

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	<p>A.M., Resident #37 was observed up in her wheel chair, an anterior support vest was in place. No seatbelt was in place.</p> <p>The clinical record for Resident #37 was reviewed on 3/10/14 at 10:33 A.M., diagnoses include but were not limited to: Dementia, anxiety, CHF, Parkinson's. The care plans included but were not limited to the following: ..."I have an enabler to my wheelchair for positioning. My butterfly vest is to help with my position."...."I have been diagnosed with Parkinson's...with the following symptoms: ...fatigue, difficulty changing positions, stooped posture ..."</p> <p>The MDS (Minimum Data Set) dated 2/7/14, indicated resident BIMS (Brief Interview for Mental Status) score was 10, indicating resident was moderately cognitively impaired. Section G indicating functional status indicated the resident required extensive assist of two plus people with transfers.</p> <p>A signed physicians order dated 1/31/13, indicated the resident was to have butterfly vest on when up in wheel chair for positioning.</p> <p>On 3/10/14 at 11:57 A.M., the manufacturer's instructions for the</p>		<p>monitoring will be forwarded to QA committee monthly x6 months and quarterly thereafter. We cordiality request paper compliance for all deficiencies.</p>				

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	<p>anterior support vest were reviewed. The instructions included, but were not limited to, the following, "...THIS IS NOT A SAFETY DEVICE. IT IS TO BE USED ONLY FOR POSITIONING. IT MUST BE USED IN CONJUNCTION WITH A METAL SEAT BELT!.... "</p> <p>The facility policy titled "(no policy date) GUIDELINES FOR RESTRAINT/ENABLER USE " was provided by the ED (Executive Director) on 3/10/14 at 11:46 A.M., the policy included, "... 5. A comprehensive plan of care shall be developed that: d. Addresses safety issues as a result of restraint/enabler use... "</p> <p>The DHS (Director of Health Services) was interviewed on 3/10/14 at 3:28 P.M., and indicated she was not aware of the manufacturer's recommendation for use of a seat belt.</p> <p>During an interview, on 3/12/14 at 1:32 P.M., a manufacturer's representative indicated a seat belt should be used for positioning, in conjunction with the vest to decrease the risk of choking.</p> <p>3.1-45(a)(1)</p>						

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