

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 09/28/2012
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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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F0000	<p>This visit was for the Investigation of Complaints IN00115496, IN00116799 and IN00117015.</p> <p>Complaint IN00115496 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00116799 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F323 and F9999.</p> <p>Complaint IN00117015 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F323 and F9999.</p> <p>Survey dates: September 26, 27, and 28, 2012</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Survey team: Jill Ross, RN</p> <p>Census bed type: SNF: 41 SNF/NF: 26 Residential: 34 Total: 101</p>	F0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey on September 28, 2012. Please accept this plan of correction as the provider's credible allegation of compliance.	

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>Census payor type: Medicare: 18 Medicaid: 18 Other: 65 Total: 101</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/04/12 by Suzanne Williams, RN</p>			
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F0309 SS=D	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident (A) was not given medication she was allergic to. This medication caused Resident A to experience hallucinations and drowsiness. This affected 1 of 10 residents reviewed for medications.</p> <p>Findings include:</p> <p>Record review for Resident A was done on 9/27/12 at 10:20 a.m. Diagnoses included but were not limited to: dementia, depression, high blood pressure, irritable bowel syndrome, peripheral vascular disease (poor circulation), arthritis and asthma. Allergies were: Codeine, morphine, penicillins and sulfa drugs. She was admitted to the facility on 8/29/12 and then readmitted on 9/14/12 after a short hospital stay.</p> <p>Resident A received Hydrocodone, a codeine derivative, 10 times before it</p>	F0309	<p>F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident A hydrocodone order was discontinued 9/26/12. Resident A was readmitted to campus on 9/14/12 with order from hospital for hydrocodone. Hospital records indicated they have codeine listed as an allergy with side effects of nausea and hydrocodone was administered during her stay. Upon readmit to the campus, all orders were verified by the MD and pharmacy. MD signed admitting orders. Pharmacist reviewed the resident's medications and medical record on 9/15 and documented there were no allergy concerns. Documentation shows the resident stated she had pain relief from the hydrocodone, had no difficulty sleeping, and participated in daily therapy and ADLs. There is no documentation of resident confirming or displaying any signs or symptoms of hallucinations or drowsiness. Identification of</p>	10/28/2012			

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	<p>was discontinued on 9/26/12. The order was dated 9/14/12 for Hydrocodone 5/325 PO (by mouth) TID (3 times a day). It was given at 7:30 p.m. and 12:00 a.m. on 9/16/12, 9/18/12 at 12:00 a.m., 9/21/12 at 3:40 a.m. and 10:50 p.m., 9/22/12 at 11:30 p.m., 9/24/12 at 3:25 a.m., 9/25/12 at 1:30 a.m. and 11:20 p.m., and 9/26/12 at 11:00 p.m.</p> <p>Resident A indicated during interview on 9/28/12 3:40 p.m., she had hallucinations each night she had received the hydrocodone. The Hydrocodone was stopped and she was given Tramadol. She slept that night and had no "weird nightmares."</p> <p>An interview with Resident A's daughter on 9/26/12 at 8:15 p.m., indicated she had told the nurses her mother was allergic to hydrocodone, but they went ahead and gave it to her. She indicated she could always tell when her mother had had hydrocodone. "She was always confused and very sleepy."</p> <p>Interviews with LPN #1 on 9/27/12 at 12:00 p.m., LPN #2 on 9/27/12 at 4:00 p.m., and RN #1 on 9/28/12 at 5:15 a.m., indicated they would not give hydrocodone to a resident who had an allergy to codeine without</p>		<p>other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Pharmacist will review current medications and allergies for all current residents to ensure that residents are no receiving a medication that he/she is allergic to. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Medication Orders How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: review of current medications and allergies to ensure that residents are not receiving a medication that he/she is allergic to. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>talking with the pharmacist, doctor and resident. Documentation indicated RN #1 had given Resident A the hydrocodone seven times.</p> <p>Interview on 9/28/12 at 1:40 p.m., with the Pharmacy Consultant, indicated he would check with the physician before giving hydrocodone to a person with a codeine allergy. "Some people can handle it and some cannot."</p> <p>A policy titled, "Medication Orders" was received on 9/26/12 at 2:15 p.m., from the Administrator. This policy stated, "...Procedures:...B. Any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified with the attending physician. C. The prescriber is contacted to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, the directions are confusing)..."</p> <p>This federal tag relates to complaints IN00116799 and IN00117015.</p> <p>3.1-37(a)</p>			

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F0323 SS=G	<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>A. Based on record review and interview, the facility failed to provide supervision and protection from accidents for Resident (A) in that during transportation from a doctor's appointment she fell out of her wheelchair, and sustained a fracture. This affected 1 out of 4 residents reviewed for falls and 1 out of 3 residents reviewed for transportation safety in the sample of 10.</p> <p>Findings include:</p> <p>A. Review of the "Vehicle Binder" and bus incident investigation, on 9/26/12 at 1:30 p.m., which was provided by the Administrator, indicated Resident A was being transported from an appointment back to the facility on 9/13/12. The bus turned a corner and the resident fell out of her wheelchair. The wheelchair was still strapped in, but the resident was on the floor. The incident occurred on 9/13/12 at 11:05 a.m. The bus driver stopped the bus, helped the resident back into the</p>	F0323	<p>F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: A). Resident A - investigation in transportation incident was complete and found that the resident had been properly strapped in with the seat belt prior to transportation. In addition, Executive Director, Director of Health Services and Assistant Director of Health Services re-enacted the incident and it was determined that the resident would have slid out of her w/c on any of the 3 prior turns or stops that had occurred before the incident. Also, that during the turn, the resident may have reached to grab onto the arms of the w/c and accidentally hit the release on the seatbelt. During an interview with the resident's daughter and Executive Director on 9/15/12, the daughter stated the resident had a mark on her right shoulder that looked like a seat belt strap. Finally, during a careplan conference with the resident and her 2 daughters on 9/27/12, the resident stated she could not remember the accident, but during an interview with the</p>	10/28/2012

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	<p>wheelchair and took the resident back to the facility. She was assessed by a nurse and transported via ambulance to a local hospital and was sent from there to a hospital in Indianapolis. She is now in a hard (Aspen) neck brace which is to be worn at all times.</p> <p>Interview with the Administrator on 9/26/12 at 1:25 p.m., indicated they believe from their investigation of the bus incident that as the driver turned the corner, the resident reached to hold on to the wheelchair and accidentally released the seatbelt.</p> <p>Record review for Resident A was done on 9/27/12 at 10:20 a.m. Diagnoses included, but were not limited to: dementia, depression, high blood pressure, irritable bowel syndrome, peripheral vascular disease (poor circulation), arthritis and asthma. She was admitted to the facility on 8/29/12 and then readmitted on 9/14/12 after a short hospital stay due to the bus incident. She came back to the facility with a new diagnosis of C1 fracture (fracture of cervical vertebra). The admission MDS (Minimum Data Set) assessment, dated 9/7/12, indicated no cognitive impairment.</p>		<p>state surveyor on 9/28/12, the resident stated the seat belt was not across her when the accident happened. B). An order has been placed to replace all side rails with openings greater than 4.75 inches and will be installed upon delivery to the campus. C). Resident C was assessed and identified as a fall risk on admission 9/17/12 per the Nursing Admission Assessment and Data Collection and the Assessment Review and Consideration. Both of these assessments were located in the medical record under the Assessments Tab at the time of the survey. After Resident C fell on 9/20/12, the nurse completed a Fall Circumstance, Assessment and Intervention form documenting the details of the fall. On 9/21/12, the Interdisciplinary Team (IDT) reviewed the Fall Circumstance, Assessment and Intervention form and the details of the fall. The root cause and new intervention was established and documented on the form, with each IDT signature. This form was located in the medical record under the Nurse's Notes tab at the time of the survey. The Nursing Admission Assessment and Data Collection form also serves as the resident's initial careplan until the admission MDS is complete and the care plans are developed. On the Nursing Admission Assessment and Data</p>		

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	<p>During interview with the driver of the bus on 9/28/12 at 12:35 p.m., she indicated she had been trained by video and watching the Maintenance Supervisor. She indicated she was sure she had strapped the resident in the wheelchair. "I always ask if the strap is OK because some of the residents don't like the seatbelt. Each wheelchair is strapped in with four floor straps and a lap belt/shoulder strap. We left the parking lot and went around a short curve and then turned onto the highway. We got to the second stop light and I made a left turn onto our road. I heard 'OH' and pulled into the first drive to the right. When I went to the back of the bus the resident was half sitting and half laying on the floor behind the seats on the passenger side. She (the resident) was trying to get up so I helped her up and in the wheelchair. I placed the seatbelt on her again. She kept telling me she was fine. I took her back to the facility and had the nurse check her out. I didn't fill out the incident report then because I had more transports to do. I did fill it out later that same day."</p> <p>Interview on 9/28/12 at 3:40 p.m., with Resident A, indicated she did not want to get any one in trouble, but the seatbelt was not across her when the</p>		<p>Collection form, which was complete on admit date of 9/17/12, the Safety Plan of Care section was updated on 9/20/12 with a new intervention post fall. This assessment form was located in the medical record under the Assessments Tab during the survey. The surveyor did not interview the Director of Nursing on 9/28/12 at 10:30am as indicated in the 2567. The surveyor did not interview of the Director of Nursing, Assistant Director of Nursing, Unit Manager or Executive Director regarding the resident's fall, documentation for the cause, interventions to be done to prevent further falls, a fall risk assessment or fall careplan. The surveyor did not ask any nursing leadership team member any questions regarding the fall, did not request assistance in finding information regarding the fall, nor did she discuss the fall as a concern during her exit on 9/28/12 with the Executive Director and Director of Nursing.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: A). All resident's transported via bus have the potential to be affected by this alleged deficient practice. There have been no other incidents or injuries with transporting residents. B). All residents have the potential be affected by the alleged deficient</p>	

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	<p>accident happened. She stated, "One minute I was in the wheelchair and the next I was on the floor. She helped me up and back into the wheelchair. I was hurting all over."</p> <p>Interview with the Administrator on 9/26/12 at 2:15 p.m., indicated they had no policy on what to do if a resident falls while on the bus - only if there is a vehicle to vehicle accident. "We have never had anything like this happen before."</p> <p>Review of "Bus Driver Orientation," received on 9/27/12 at 6:10 p.m., showed this bus driver had been trained "...1. Operation of bus including handling and parking of vehicle 2. Safe operation of the hydraulic lift 3. Securing of wheelchair resident on the bus 4. Filling gas tank, windshield wiper fluid. 5. Use of cell phone, location of first aid kit. 6. Use of log and record keeping procedures." All had been initialed, signed and dated 6/19/12 by this bus driver.</p> <p>Review of another training form received 9/27/12 at 9:05 a.m., indicated this bus driver had received training on 9/14/12 and 9/17/12 for "Procedure on bus for accidents, return demonstration, check proper</p>		<p>practice. There have been no accidents or no injuries involving the side rail openings. C). Resident's with falls for the past 30 days will be reviewed to ensure that there is documentation on the following: root cause, interventions, risk assessment and careplan implementation or update.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: A). ED will ensure that Employees designated to transport residents in the campus bus will be re-educated on the Resident Transportation Policy and will review again the video entitled Doing it Right: Wheelchair Securement and Restraint System. B). Any new side rails that are ordered will be inspected by the DPO or designee to ensure any openings area not greater than 4.75 inches. ED or designee will educate our Hospice providers on the side rail requirement that no opening can be greater than 4.75 inches and any bed with side rails that they provide must comply with these requirements. C). DHS or designee will re-educate the Licensed Nurses on the campus guideline for Fall Management Program. The DHS or designee will re-educate the Careplan Team on the campus guideline for Interdisciplinary Team Care Plan. How the corrective</p>		

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	<p>loading, check wheelchair on bus."</p> <p>There have been no other problems with transporting residents found during this review.</p> <p>This federal tag relates to complaints IN00116799 and IN00117015.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>measures will be monitored to ensure the alleged deficient practice does not recur: A). The following audits of up to 5 residents, who are secured on the bus prior to transportation, will be conducted by the DPO or designee 1 time per week times 4 weeks, then monthly times 5 months to ensure the residents are properly secured with safety belts. B). Any new side rails that are ordered will be inspected by the DPO or designee to ensure any openings are not greater than 4.75 inches. The ED or designee will audit all side rails in place weekly x 4 weeks then monthly x 5 months to ensure the openings are not greater than 4.75 inches. C). The following audits of 5 resident falls will be conducted by the DHS or designee 1 time per week times 4 weeks, then monthly times 5 months to ensure compliance: Documented root cause, interventions, risk assessment and careplan implementation or update. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F9999	<p>State Finding:</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(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:</p> <p>(1) Immediately informing the division by telephone, followed by a 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:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>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.</p> <p>This state rule was not met as evidenced by:</p>	F9999	<p>F 9999</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The campus did complete a full investigation for the bus incident involving Resident A. The surveyor conducting the complaint survey reviewed the investigation. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: ED will review the incident reports for last 5 days to ensure, if applicable, any reportable event per the campus guidelines was submitted to the State Department of Health.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Clinical Support Nurse will re-educate the Executive Director (ED) and Director of Health Services (DHS) on the following campus guidelines: State Reportable Events</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does</p>	10/28/2012	

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	<p>Based on record review and interview, the facility failed to report an accident on a facility bus resulting in Resident A sustaining a fracture in her neck. This affected 1 of 1 bus incident reviewed for facility reporting out of 10 residents who use the facility bus for transportation.</p> <p>Findings include:</p> <p>According to an investigative report received on 9/26/12 at 1:30 p.m., from the Administrator, there was an incident on the facility bus on 9/13/12 at 11:05 a.m., in which Resident A fell out of her wheelchair while the bus was turning. She was assisted back into wheelchair and taken back to the facility, assessed and then sent to the emergency room of a local hospital. The resident sustained a C1 fracture (cervical vertebra) in her neck. There was an investigation done but none of this was reported by the facility to ISDH (Indiana State Department of Health).</p> <p>An interview with the Administrator on 9/26/12 at 1:25 p.m., indicated, "Didn't report. Resident was alert and oriented and up on her own."</p> <p>This state finding relates to</p>		<p>not recur: The following audits and /or observations will be conducted by the ED or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: review of all incident reports. If an incident is deemed a reportable event based the campus guidelines, the ED will report it to the State Department of Health.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</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 09/28/2012
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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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	<p>complaints IN00116799 and IN00117015.</p> <p>3.1-13(g)(1)</p>			