

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 24, 25, 26, 27, and 28, 2014.</p> <p>Facility number: 000569 Provider number: 155531 AIM number: 100267600</p> <p>Survey Team: Karen K. Koeberlein, RN, TC Kim Davis, RN Jason Mench, RN Angela Selleck, RN</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 7 Medicaid: 33 Total: 40</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
---------	--	---------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure 1 resident was free of verbal abuse. (Resident #16)</p> <p>Findings Include:</p> <p>Resident # 16 was interviewed on 3/25/14 at 10:00 a.m. During the interview Resident #16 indicated a Certified Nursing Assistant (CNA #1) had been rude to her over the weekend. The resident indicated the CNA refused to provide care for her and raised her voice to the resident. The resident indicated she had spoken with three people from the office and the staff told her this was abuse.</p> <p>The Administrator was interviewed on 3/25/14 at 12:00 p.m. The Administrator provided the investigation of allegation of abuse. The administrator indicated the initial incident was reported to the</p>	F000223	<p>F223</p> <ol style="list-style-type: none"> Resident 16's allegation was immediately investigated, and reported to ISDH per facility policy. A mental anguish assessment was completed for resident 16 with no negative findings. Upon investigation, the allegation was substantiated, and the staff member involved was terminated. All other residents have the potential to be affected. The facility conducts education regarding abuse policy and procedure upon hire, and periodically thereafter. The facility will continue to follow its policy regarding abuse prohibition and investigation of reported abuse, as occurred with this resident. The facility continues to conduct criminal background checks prior to hire of any staff member. The Administrator will assure that the facility conducts education regarding abuse policy and procedure upon hire, and periodically thereafter. The facility will continue to follow its policy regarding abuse prohibition and 	04/27/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>State Agency.</p> <p>The Administrator was again interviewed on 3/25/14 at 1:00 p.m. The Administrator indicated he had a meeting scheduled with CNA #1 at 2:00 p.m. on 3/25/14 and at that time the CNA was going to be terminated for the verbal abuse.</p> <p>The facility policy, "Abuse Prohibition, Reporting and Investigation Policy and Procedure", dated 05/2013, was presented by the Administrator on 3/25/14 at 12:50 p.m. The policy indicated, "... Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting physical harm or pain, anguish or deprivation an individual of goods or services that to attain or maintain physical, mental or psychosocial well-being... Verbal Abuse - Episodes of oral, written and/or gestured language that includes disparaging and derogatory remarks to residents...".</p> <p>3.1-27(b)</p>		<p>investigation of reported abuse, and that the facility continues to conduct criminal background checks prior to hire of any staff member.</p> <p>4. The Administrator will report to the QAA committee any reports of abuse, and any further follow up monthly x 3 months then quarterly thereafter.</p> <p>5. 4-27-14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure choices for bedtime and wake up times were respected for 3 of 19 residents interviewed regarding wake time and bedtime. (Residents #16, 36, and 41).</p> <p>Findings include:</p> <p>1. Resident #16 was interviewed on 3/25/14 at 10:00 a.m. During the interview, the resident indicated she could not choose when she got up in the morning or went to bed at night. Resident #16 indicated when she was at home, she went to bed after 11:00 p.m. and got up around 10:00 a.m. The resident indicated she was on a second shift schedule.</p> <p>Resident #16 indicated she was asked her preferences of waking and bedtime, but these times were not honored by staff.</p>	F000242	<p>F242</p> <p>1. Residents #16, 36 and 41 were interviewed to ensure choices for bedtime and wake up time are respected. Medication/Meal times changed as necessary, and C.N.A. assignment sheets updated.</p> <p>2. Social Service designee has conducted interviews for all residents to ensure their wishes for bedtime and wake up times are respected. Wake up or bedtimes which were not acceptable to the resident were changed to meet their preference, as well as Medication/meal times. The DON has updated the C.N.A. assignment sheets to ensure staff awareness of the resident preference.</p> <p>3. Resident interviews regarding preferences will be completed monthly for 3 months, then 3 random residents monthly thereafter to ensure preferences are honored. The facility will continue to conduct interviews upon admission and every 6 months.</p> <p>4. Social Services and/or designee will report the findings of</p>	04/27/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>Resident #16 indicated she was awakened around 6:30 a.m. for a breathing treatment, then again with her breakfast around 8:00 a.m.</p> <p>Resident #16 indicated staff turned off all the lights by 9:00 p.m., and it was time for bed whether she was ready or not.</p> <p>The clinical record of Resident #16 was reviewed on 3/26/14 at 10:10 a.m. The record indicated the resident's diagnoses included, but were not limited to, high blood pressure, asthma, stoke, and pneumonia.</p> <p>The Physician Orders signed by the physician on 3/6/14 included an order for Duoneb (breathing treatment) to be administered by a nebulizer treatment three times a day.</p> <p>The "Daily Preferences" care plan, dated 1/21/14, indicated it was important to Resident #16 to make her own daily decisions regarding her daily routine. The care plan indicated Resident #16 wanted to go to bed when she was tired. The preferences regarding wake up time and meal times were not completed.</p> <p>The Respiratory Therapist #2 was</p>		<p>these interviews, and any corrective actions taken to the QAA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan if warranted.</p> <p>5. 4-27-14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>interviewed on 3/26/14 at 10:20 a.m. During the interview, the Respiratory Therapist indicated she administered the resident's breathing treatment everyday between 6:30 a.m. and 7:15 a.m. The therapist indicated the treatments were administered three times a day and there was no real reason that they couldn't be administered later. The therapist indicated she didn't interview the resident about her choices. She had put the resident on a schedule like everyone else.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 3/26/14 at 10:40 a.m. The CDM indicated she knew breakfast was taken to Resident #16 every morning around 8:00 a.m. She indicated staff sometimes warmed up the breakfast. The CDM indicated staff had not considered a continental type breakfast for the resident that she could eat when she chose to eat. The CDM indicated food was available in the pantry at the nurse station.</p> <p>The Social Service Director (SSD) on 3/26/14 at 10:45 a.m., the SSD indicated she had not asked Resident #16 her preference for the breathing treatments, morning medications, time for getting up, or eating</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>breakfast. The SSD indicated she was unaware as to what the resident was being served for breakfast. The SSD indicated she was unaware of the area on the " Daily Preference" form regarding choice for getting up in the morning.</p> <p>CNA # 6 was interviewed on 3/25/14 at 3:40 p.m. During the interview, CNA #6 indicated CNA sheets with resident information did not provide resident preferences for getting up in the morning or going to bed at night. The CNA indicated they just pretty much know when residents want to go bed and residents are in bed by 9:00 p.m.</p> <p>2. Resident #36 was interviewed on 3/25/14 at 3:00 p.m. During the interview, Resident #36 indicated she did not choose when she wanted to get up in the morning. Resident #36 indicated staff are busy and have a lot to do. Resident #36 indicated she gets up when staff come in because they don't have time to come back later.</p> <p>The clinical record of Resident #36 was reviewed on 3/25/14 at 3:00 p.m. The record indicated the resident's diagnoses included, but were not limited to, lumbar spondyliditosis,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>frequent falls, osteopenia, chronic leg pain, and anxiety.</p> <p>The current Physician Orders, signed on 3/4/14, indicated medications were given to Resident #36 at 7:00 a.m. every morning.</p> <p>The Daily Preference Care Plan Worksheet, dated 1/9/14, indicated, "...Prefers to waken at _____". This area of the Daily Preference Care Plan Worksheet was not completed.</p> <p>The current Certified Nursing Assistant (CNA) assignment sheets were provided by LPN #7 on 3/26/14 at 3:30 p.m. The CNA sheets indicated, Resident #36 required staff assistance for transfer and took a shower two times a week on the day shift. The assignment sheets did not include any information as to when Resident #36 chose to get up in the morning or go to bed at night.</p> <p>CNA #7 was interviewed on 3/26/14 at 8:45 a.m. During the interview, CNA # indicated the assignment sheets did not include a time when residents desire to get up in the morning. CNA #7 indicated she just goes into rooms and gets residents up.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>CNA #7 was interviewed on 3/27/14 at 7:30 a.m. The CNA indicated she had given all her showers to resident all ready this morning.</p> <p>The Social Service Director (SSD) was interviewed on 3/26/14 at 10:45 a.m. During the interview, the SSD indicated she was unaware of the area on the " Daily Preference" form regarding choice for getting up in the morning.</p> <p>3. Resident #15 was interviewed on 3/25/14 at 10:20 a.m. During the interview, Resident #15 indicated she could not choose when she got out of bed in the mornings. The resident indicated the staff turn on the lights early in the morning. The resident indicated staff have too many people to "mess with" in the mornings, so she just gets up when the staff come in.</p> <p>The clinical record of Resident #15 was reviewed on 3/26/14 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, high blood pressure, stroke, renal insufficiency, and gastritis.</p> <p>The current Physician orders indicated a medication was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>administered at 7:00 a.m. every morning.</p> <p>The Care Plan, dated 12/18/13, indicated it was very important to the resident to choose her own wake time and bed time. The care plan indicated Resident #15 wanted to go to bed when she got sleepy. The section regarding wake time was not completed.</p> <p>The current Certified Nursing Assistant (CNA) assignment sheet indicated Resident #15 took her showers during the day shift and required staff assistance for transfers. The assignment sheet did not include a time when Resident #15 chose to get out of bed in the morning or go to bed at night.</p> <p>CNA #4 was interviewed on 3/26/14 at 12:15 p.m. During the interview, the CNA indicated she walks into the resident's room and says good morning and the resident is usually awake, so the CNA helps the resident get out of bed. The CNA indicated, she does not ask Resident #15 if she is ready to get out of bed.</p> <p>The Social Service Director (SSD) was interviewed on 3/26/14 at 10:45 a.m. During the interview, the SSD</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>indicated she was unaware of the area on the " Daily Preference" form regarding choice for getting up in the morning.</p> <p>4. The facility policy entitled, "Resident Interviews", dated 9/10, was presented by the facility's Nurse Consultant on 3/28/14 at 1:00 p.m. The policy indicated:</p> <p>"1. Social Service staff shall be responsible to complete an initial resident interview with a resident identified as interviewable. 2. Subsequent resident interviews shall be conducted on at least a quarterly basis at the time of the resident assessment/careplan...4. Any information gained that is relevant to the resident's plan of care shall be communicated to the interdisciplinary team and revisions made to the plan of care in accordance with the resident's former routine/choices, as possible.</p> <p>3.1-(u)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide Behavior Management documentation to monitor the behaviors for 1 of 5 residents reviewed for behavior management (#34).</p> <p>Findings Include:</p> <p>The clinical record of Resident # 34 was reviewed on 3/26/14 at 9:40 a.m. The record indicated the resident's diagnoses included, but were not limited to, dementia with delusions and psychosis, hypothyroidism and hypertension.</p> <p>Resident #34 was found to have had her medication Zyprexa (an antipsychotic medication) increased from 5 milligrams (mg) by mouth at bedtime every night to 7.5mg by mouth at bedtime every night. This order began on 12/10/13 by the facility's psychiatrist Nurse Practitioner for reports by staff of the resident being combative since last Gradual Dose Reduction (GDR) of</p>	F000250	<p>F250</p> <ol style="list-style-type: none"> Resident # 34- The physician, and the residents' mental health provider were notified of the medication management, and orders reviewed. Follow up and assessment on next visit. Staff were re-educated on the importance of accurate documentation related to Behavior Management, and the use of the mood and behavior monitoring tools. Physician orders reviewed to identify residents receiving psychoactive medications. Behavior Management documentation for all residents who receive psychoactive medication was reviewed to assure proper documentation in place. All staff were re-educated on the facility policy and procedure for Mood and Behavior Monitoring. The DON and/or designee will audit the physicians' orders, the 24 hour report sheets and the nursing notes 5 xs weekly to ensure compliance. The SSD will bring the Mood/Behavior monitoring sheets to the daily stand up meeting (5 xs weekly) for review and comparison to the DON/Designee findings. The Social Service Designee will track the reports, and report the 	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Zyprexa on 6/25/13.</p> <p>Resident had 3 incidents of a behavior of "smacking at staff" documented in the time period since the last GDR These behaviors occurred on 11/21/13, 11/22/13 and 12/4/13.</p> <p>During an interview with the Social Service Designee (SSD) on 3/27/14 at 1:51 p.m., the SSD indicated from her meetings with staff, Resident #34 was having episodes of smacking at staff when being resistive to care 3 times a week to every night before the increase of her Zyprexa. Since the increase of the Zyprexa Resident #34 has not been having any of these behaviors. The Social Service Designee indicated that she reinforces the need to fill out the "Mood and Behavior Communication Memo" to the staff at every monthly meeting.</p> <p>In a policy named "Mood and Behavior Program Procedures", provided by the Social Service Consultant on 3/28/14 at 1:00 p.m., dated July, 2010:</p> <p>"...the Mood and Behavior Communication Memo form will be completed by all staff members upon</p>		<p>findings of audits, and any corrective actions taken to the QAA committee monthly x 3 and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	witnessing a mood and/or behavior...." 3.1-34(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a plan of care was developed for 1 of 5 residents reviewed for unnecessary medications and for 2 of 2 residents reviewed for rehabilitation services. (Resident #32, #7 and #49).</p> <p>Findings include:</p> <p>The clinical record of Resident #32 was reviewed on 3/28/14 at 9:30 a.m. The record indicated the resident's diagnoses included, but were not</p>	F000279	<p>F279</p> <ol style="list-style-type: none"> Resident #32's care plan was updated to include hypoglycemia and hyperglycemia. Resident # 7 and 48 care plans were updated to include therapy services. Care plan audit completed and revisions as necessary to ensure all residents had updated and accurate care plans for medications and therapy needs. Any revisions necessary have been completed. The DON and/or designee will audit the 24 hour report sheets, the physicians' orders and all admission/re-admission orders 5 xs weekly to assure necessary information 	04/27/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>limited to, steroid induced hyperglycemia, depression, anxiety disorder, anemia, bipolar disorder, dementia, altered mental status, rheumatoid arthritis, neuropathy, acute viral illness, urinary tract infection and history of deep vein thrombosis.</p> <p>The March 2014 Physician rewrite orders included an undated medication order for Humulin R three times a day before meals per sliding scale and to call Physician if blood sugar less than 60 or greater than 350. An order, dated 3/6/14, for Prednisone 5 milligrams one tablet by mouth twice daily per original order.</p> <p>Review of Resident 32's current care plans indicated there was no care plan to monitor the side effects of insulin related to prednisone use. There was no care plan to monitor for hypoglycemia or hyperglycemia.</p> <p>During an interview with the Director of Nursing (D.o.N.), on 3/28/14 at 1:10 p.m., she indicated Resident #32 had a physician order for insulin and blood sugar checks since September 2013. She also indicated the resident was on insulin and blood sugar checks due to a diagnosis of steroid induced hyperglycemia and</p>		<p>including new medications and therapy care plans are complete and accurate.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QAA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted</p> <p>5. 4-27-14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>elevated A1C glucose level. The D.o.N also indicated there was no care plan related to hypoglycemia and hyperglycemia for Resident #32 prior to the clinical record review on 3/28/14.</p> <p>No further information was presented at exit on 3/28/14 at 3:20 p.m.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>2. Resident #7's record was reviewed on 3/25/14 at 3:00 p.m. The diagnoses included, but were not limited to, morbid obesity, congestive heart failure (CHF), neck pain, history of a stroke and chronic neuropathy.</p> <p>Resident #7 had an active order from the Physician for physical therapy and occupational therapy to evaluate and treat Resident #7. Review of Resident #7's care plan lacked any plan that addressed what physical therapy or occupational therapy was addressing with Resident #7 or how</p>	F000279	<p>F279</p> <p>1. Resident #32's care plan was updated to include hypoglycemia and hyperglycemia. Resident # 7 and 48 care plans were updated to include therapy services.</p> <p>2. Care plan audit completed and revisions as necessary to ensure all residents had updated and accurate care plans for medications and therapy needs. Any revisions necessary have been completed.</p> <p>3. The DON and/or designee will audit the 24 hour report sheets, the physicians' orders and all admission/re-admission orders 5 xs weekly to assure necessary information</p>	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>often they were addressing those concerns.</p> <p>On 3/27/14 at 9:15 a.m., Resident #7 was observed in therapy working with the Occupational Therapist. She was working on upper body strengthening and actively participating with minimal cues.</p> <p>During an interview with the Director of Nursing (DoN) and Nurse Consultant on 3/27/14 at 9:30 a.m., they both indicated they could not find a care plan addressing physical and occupational therapy the resident was receiving and it would be fixed immediately.</p> <p>3. Resident #48's record was reviewed on 3/26/14 at 8:20 a.m. The diagnoses included, but were not limited to, diabetic neuropathy, osteoporosis and chronic edema.</p> <p>Resident #48 had an active order from the Physician for physical therapy and occupational therapy to evaluate and treat Resident #48. Review of Resident #48's care plan lacked any plan that addressed what physical therapy or occupational therapy was addressing with Resident #48 or how often they were addressing those concerns.</p>		<p>including new medications and therapy care plans are complete and accurate.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QAA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted</p> <p>5. 4-27-14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>During an interview with the Nurse Consultant, on 3/27/14 at 10:10 a.m., she indicated that she could not find a care plan addressing physical and occupational therapy the resident was receiving and that it would be fixed immediately.</p> <p>4. In a policy named "Care Plan Development and Review Procedure", provided by the Nurse Consultant on 3/28/14 at 1:00 p.m., dated November, 2011:</p> <p>"Purpose: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs.</p> <p>Policy:</p> <p>1. And interdisciplinary team, in coordination with the resident and his/her family will develop a comprehensive care plan for each resident.</p> <p>2. The comprehensive care plan has been designed to:</p> <p>Incorporate identified problem areas. Incorporate risk factors associated with identified problems.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>Build on the resident's strengths. Reflect treatment goals and objectives in measurable outcomes Identify the professional services that are responsible for each element of care. Prevent the declines in the resident's functional status and/or functional levels. Enhance the optimal functioning of the resident by focusing on a rehab program....</p> <p>...Communication to Staff:</p> <p>1. Care plans will be available to all staff caring for the residents.</p> <p>2. Care plan interventions specific to the direct care staff will be transferred to the nurse aide assignment sheet...."</p> <p>3.1-35(a)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
F000282 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, interview, and record review, the facility failed to ensure a doctor's order for a gynecology consult was followed for 1 of 21 residents reviewed for following doctor's orders. b. In addition, the facility failed to ensure a dietician recommendation was acted upon timely for 1 of 1 resident reviewed for dietary recommendations. (Resident #37)</p> <p>Findings Include:</p> <p>1.a. The clinical record of Resident #37 was reviewed on 3/26/14 at 12:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, pressure sores, incontinence, and malnutrition.</p> <p>The Initial Nursing Assessment, dated 1/15/14, indicated Resident #37 had no perception of voiding and dribbled urine constantly and saturated pads. The assessment further indicated the resident was at risk for skin-related complications due to functional incontinence, defined in</p>	F000282	<p>F282</p> <ol style="list-style-type: none"> Resident #37 Gynecology appointment was rescheduled and completed with no new orders at this time. The dietary recommendation was obtained. All physicians' orders for the past 30 days were reviewed to identify any resident with an outside appointment to ensure it was scheduled and obtained. The Dietary recommendations for the past 30 days were reviewed to ensure orders were obtained timely. Licensed staff were re-educated on ensuring all appointments are obtained timely, and any appointments that are cancelled are re-scheduled timely, as well as dietary recommendations to be communicated to the physician timely, and orders received as indicated. The DON and/or designee will monitor 24 hour report sheets, physicians orders, and nurses notes 5 x weekly to ensure appointments obtained timely, and if an appointment is cancelled for any reason, it is rescheduled for a timely visit. The dietary recommendations will be monitored by the DON and/or designee for timely physician notification and orders received as 	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>the assessment as the inability to toilet due to cognitive and/or physical function. The assessment further indicated Resident #37 was admitted to the facility with pressure sores on the buttocks.</p> <p>A doctor's telephone order, dated 1/19/14, indicated Resident #37 was to have a gynecologist consult.</p> <p>A doctor's telephone order, dated 3/10/14, indicated a Foley catheter was to be placed due to the pressure sores.</p> <p>Further review of doctor telephone orders indicated the use of antibiotics three times between January and March 2014 for wound infections. The antibiotic Augmentin was ordered on 1/20/14, Bactrim DS on 2/7/14, and Rocephin injections daily for five days and Levequin orally for ten days on 2/26/14.</p> <p>RN #3 was interviewed on 3/26/14 at 8:45 a.m. During the interview, RN #3 indicated before the catheter was placed there was lots of green drainage coming from Resident #37's wounds. RN #3 indicated the resident constantly dribbled urine. Resident #37 leaked urine around the catheter tubing as well.</p>		<p>indicated. The assigned Nurse Consultant will audit appointments and Dietary recommendations on scheduled visits.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>RN #3 was interviewed on 3/27/14 at 9:00 a.m. During the interview, RN #3 indicated the doctor had known Resident #37's history. The doctor had told facility staff the resident dribbled urine and needed to have a gynecologist appointment to have a suspension procedure done. RN #3 indicated the resident had not had the appointment and that's why the facility staff had requested the doctor order the Foley catheter.</p> <p>The Director of Nursing (DoN) was interviewed on 3/28/14 at 9:30 a.m. The DoN indicated the appointment was made then canceled by the gynecologist some time ago. The DoN indicated the facility had not rescheduled the appointment or attempted to make an appointment with another gynecologist.</p> <p>1.b. Resident #37 was assessed by the Registered Dietician (RD) on 1/28/14. The RD note included a recommendation for Arginaid, a high protein supplement to aid in the healing of the resident's pressure ulcers.</p> <p>Review of the telephone orders indicated an order written on 2/3/14 for supplement to aid in the healing of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>the resident's pressure ulcers.</p> <p>The Director of Nursing (DoN) was interviewed on 3/28/14 at 9:45 a.m. During the interview, the DoN indicated the supplement order was not relayed to the doctor timely because he was on vacation on 1/28/14. The DoN indicated an on call physician was available during the house doctor's absence but the nurses did not ask the on call physician for orders that were not an emergency.</p> <p>3.1-35(g)(1)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

F000314 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 observation, interview, and record review, the facility failed to ensure the accuracy of assessments, treatments performed as ordered, and nutritional supplements provided as recommended for 1 of 1 residents reviewed for pressure sores. (Resident #37)</p> <p>Findings Include:</p> <p>The clinical record of Resident #37 was reviewed on 3/26/14 at 12:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, pressure sores, incontinence, and malnutrition.</p> <p>The "Weekly Facility Skin Summary" sheet, dated 1/17/14, indicated Resident #37 was admitted to the facility with eight different pressure sores. The summary indicated two of</p>	F000314	<p>F314</p> <ol style="list-style-type: none"> The skin assessment record for resident #37 was reviewed and updated as necessary. Staff were re-educated on the use of linens for resident #37 air mattress. The staff were re-educated regarding the proper shower/bathing technique for resident #37 and the importance of coordinating dressing change and shower. Resident #37 receives nutritional supplements per physicians order. Skin assessments were completed for all residents. Weekly skin assessment summary sheets were reviewed to confirm accuracy. Residents with air mattresses currently in use were observed to assure proper linen use. Residents with dressings were observed to assure dressings intact. Any concerns identified will be addressed immediately. Staff were re-educated on the proper linens to be used with air mattresses, and the 	04/27/2014
-----------------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>these areas could not be staged because black eschar was present.</p> <p>The March 2014 Physician orders, signed on 3/4/14, included daily treatments for packing and dressing the resident's pressure sores.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 2/8/14, indicated Resident #37 had four pressure ulcers, one that could not be staged due to black eschar.</p> <p>The Care Plan, dated 1/15/14, indicated Resident #37 had pressure sores. The Care Plan Interventions included, a special mattress, chair cushion, a Dietician referral, vitamins and nutritional supplements.</p> <p>On 3/26/14 at 8:45 a.m., Resident #37 wheeled herself to her room after breakfast for her dressing changes. The resident was assisted to bed by staff.</p> <p>The treatment of Resident #37's wounds was observed after breakfast on 3/26/14 at 8:45 a.m. with RN #3. During the observation, one of the four pressure ulcers on the resident's buttocks was not covered by a dressing. The resident was wearing a brief, all though she had a Foley</p>		<p>coordination of care for residents with dressings to assure the dressings remain intact and properly secured. Dietary recommendations and physicians orders for the past 30 days were reviewed to assure nutritional supplements ordered timely.</p> <p>3. The DON and/or designee will monitor the 24 hour report sheets, physicians' orders, nurses notes 5 xs weekly to assure orders received timely. The DON and/or designee will monitor the residents on air mattresses 5 xs weekly x 1 month then weekly thereafter, to assure proper linen use. The DON and/or designee will monitor the weekly skin assessment summary sheets 5 xs weekly x 1 month than weekly thereafter, to assure proper documentation. The DON and/or designee will assure dietary recommendations are communicated to the physician with timely initiation of orders. The DON and/or designee will monitor residents with dressings 3 xs per week x 1 month then monthly thereafter, to assure coordination of care and correct dressing change procedure followed. Should concerns be noted during the aforementioned observations/audits, corrective action shall be taken.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>catheter for urine and colostomy bag for stool.</p> <p>RN #3 was interviewed on 3/26/14 at 9:00 a.m. During the interview, RN #3 indicated Resident #37 had a shower early in the morning and the dressings sometimes fell off during a shower. RN #3 did not know for certain how long the dressing had been off. RN #3 indicated sometimes the Foley catheter leaked.</p> <p>On 3/24/14 at 10:30 a.m., two bed pads on top of a bottom sheet were observed on Resident #37's air bed.</p> <p>On 3/25/14 at 2:45 p.m., two bed pads and a bottom sheet were observed on Resident #37's air mattress.</p> <p>On 3/26/14 at 10:00 a.m., one bed pad and a bottom sheet were observed on Resident #37's air mattress.</p> <p>On 3/27/14 at 7:20 a.m., two bed pads and a bottom sheet were observed on Resident #37's air mattress.</p> <p>Certified Nursing Assistant (CNA) #6 was interviewed on 3/27/14 at 2:30 p.m. During the interview, the CNA</p>		<p>x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>indicated staff used two bed pads on top of the bottom sheet on Resident #37's air mattress to protect the mattress. CNA #6 indicated sometimes the colostomy bag or the Foley catheter leaked.</p> <p>The facility Assistant Director of Nursing (ADoN) served as the facility wound nurse. During an interview with the ADoN on 3/27/14 at 2:10 p.m., the nurse indicated extra pads were not to be on air mattresses because the pads cause extra pressure on the resident.</p> <p>During an interview with Resident #37 on 3/25/14 at 10:00 a.m., the resident was observed in bed on an air mattress for wound healing. Resident #37 laid on two bed pads on top of a bottom sheet.</p> <p>The Director of Nursing was interviewed on 3/28/14 at 9:30 a.m. During the interview, the DoN indicated nothing but a bottom sheet could be on top of the air mattress. The DoN indicated added padding created more pressure on the resident.</p> <p>The undated manufacturer's recommendations for the air mattress on Resident #37's was presented by</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>the DoN on 3/28/14 at 9:45 a.m. The recommendations indicated, "...Special lines are not necessary for the MaXair. There is no need for a bottom sheet as the therapy pad should be covering the therapy cells at all times. The resident should never be laying directly on the therapy cells. Based upon the resident's specific needs, the following linens may be utilized: draw sheet or slide sheet to aid in positioning and to further minimize friction and shearing. Add top sheet, blanket, and/or bedspread as needed for resident comfort..."</p> <p>The facility policy entitled, "Skin Management Program", dated 1/11, was presented by the facility's Nurse Consultant on 3/28/14 at 1:00 p.m. The policy indicated:</p> <p>"...12. Routine education will be provided to licensed nurses at least annually to review the clinical aspects of developing pressure areas, staging, wound assessment, measurement,s/s (signs and symptoms) of infection, culturing wounds, treatment options, dressing options, and documentation.</p> <p>13. Routine education will be provided to unlicensed nursing staff</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>at least annually to review the risk factors, minimum preventative measures, incontinence care, routine skin care, positioning/turning, transfers, use of positioning devices, and mobility..."</p> <p>3.1-40(a)(2)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 1 residents reviewed for incontinence received the appropriate, prescribed treatment to treat the incontinence to protect 4 pressure areas from infection. (Resident #37)</p> <p>Findings Include:</p> <p>The clinical record of Resident #37 was reviewed on 3/26/14 at 12:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, pressure sores, incontinence, and malnutrition.</p> <p>The Initial Nursing Assessment, dated 1/15/14, indicated Resident #37 had no perception of voiding and dribbled urine constantly and saturated pads. The assessment</p>	F000315	F 3151. Resident #37 continues to have in place a Foley catheter for the treatment of the pressure ulcers. Resident #37 has had the Gynecology appointment, with no new orders at this time.2. All residents' records reviewed to ensure the appropriate, prescribed treatment is obtained for residents with incontinence and pressure areas. Any identified concerns corrected immediately.3. Licensed Staff re-educated concerning the appropriate treatment for residents with incontinence and pressure areas. The DON and/or designee will monitor residents weekly x 1 month then monthly to assure appropriate, prescribed treatment is obtained when necessary. Should concerns be noted, corrective actions shall be taken.4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>further indicated the resident was at risk for skin-related complications due to functional incontinence, defined in the assessment as the inability to toilet due to cognitive and/or physical function. The assessment further indicated Resident #37 was admitted to the facility with pressure sores on the buttocks.</p> <p>A doctor's telephone order, dated 1/19/14, indicated Resident #37 was to have a gynecologist consult.</p> <p>A doctor's telephone order, dated 3/10/14, indicated a Foley catheter was to be placed due to the pressure sores.</p> <p>A Care Plan, dated 3/10/14, indicated Resident #37 had a Foley catheter for Stage Three pressure sores.</p> <p>Further review of doctor telephone orders indicated the use of antibiotics three times between January and March 2014 for wound infections. The antibiotic Augmentin was ordered on 1/20/14, Bactrim DS on 2/7/14, and Rocephin injections daily for five days and Levequin orally for ten days on 2/26/14.</p> <p>Following an observation of Resident #37's wounds and Foley catheter on</p>		and quarterly thereafter, and revisions made to the plan, if warranted.5. 4-27-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>3/26/14 at 8:45 a.m., RN #3 was interviewed. During the interview, RN #3 indicated before the catheter was placed there was lots of green drainage coming from Resident #37's wounds. RN #3 indicated the resident constantly dribbled urine. Resident #37 leaked urine around the catheter tubing as well, but not as much urine got into the pressure sores as before the catheter was placed.</p> <p>RN #3 was interviewed on 3/27/14 at 9:00 a.m. During the interview, RN # indicated the doctor had known Resident #37's history. The doctor had told facility staff the resident dribbled urine and needed to have a gynecologist appointment to have a suspension procedure done. RN # indicated the resident had not had the appointment and that's why the facility staff had requested the doctor order the Foley catheter.</p> <p>Certified Nursing Assistant #4 was interviewed on 3/27/14 at 8:30 a.m. During the interview CNA #4 indicated Resident #37's catheter leaked unto the bed and into her wounds off and on.</p> <p>The Director of Nursing (DoN) was interviewed on 3/28/14 at 9:30 a.m.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>The DoN indicated the appointment was made then canceled by the gynecologist some time ago. The DoN indicated the facility had not rescheduled the appointment or attempted to make an appointment with another gynecologist.</p> <p>3.1-41(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure a resident with a physician's order for a splint, received the splint as ordered, for treatment of a contracture. This deficiency affected 1 of 1 residents residing in the facility who were reviewed for contractures (Resident #13).</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 3/25/14 at 10:35 a.m. Diagnoses included, but were not limited to, dementia, depression, arthritis, and history of stroke. The most recent quarterly Minimum Data Set (MDS), dated 9/26/13, and provided by the MDS coordinator on 3/27/14 at 2:15 p.m., indicated Resident #13 had severe cognitive impairment.</p> <p>During an observation on 3/25/14, at 10:15 a.m., Resident #13 was sitting in her room, awake and alert.</p>	F000318	<p>F318</p> <ol style="list-style-type: none"> Resident #13 received a therapy evaluation on 3-26-14 with recommendation to develop a ROM/splinting program. A palm protector is to be used as tolerated and removed for hygiene. Physicians' orders reviewed to assure splint use per Therapy recommendation for applicable residents. Therapy Manager and/or designee will monitor residents' splint use on scheduled work days x 1 month, then monthly thereafter, to assure splint schedules are being followed. The Therapy Manager and/or designee will monitor residents' splint use as ordered on scheduled work days x 1 month, then monthly thereafter to assure splint schedules are being followed. Should concerns be observed, corrective action will be taken. The Therapy Manager and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted. 	04/27/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>Resident #13 was observed to have a contracture to the right hand. The contracture did not have a splint in place.</p> <p>During additional observations on 3/25/14 at 12:05 p.m., 3/26/14 at 9:30 a.m., 3/26/14 at 1:45 p.m., 3/27/14 at 8:30 a.m., 3/27/14 at 2:45 p.m., 3/28/14 at 9:00 a.m., and 3/28/14 at 1:15 p.m., Resident #13 was observed to never have a splint in place on the right hand.</p> <p>Review of the clinical record for Resident #13 on 3/25/14, at 10:35 a.m., indicated there was a current physician order in place for a splint to the right hand with an original start date of 7/20/11.</p> <p>During an interview on 3/25/14 at 10:45 a.m., the Director of Nursing (DoN) indicated the splint for Resident #13 was to be applied daily by the restorative aid, and was to be positioned on Resident #13's right hand for periods of two hours, as tolerated. The DoN also indicated Resident #13 had recently been hospitalized, and the order for the splint was discontinued upon discharge to the hospital.</p> <p>During an interview on 3/25/14 at</p>		5. 4-27-14	
--	---	--	------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>10:55 a.m., Restorative Aid (RA) #8 indicated when residents are discharged to the hospital, she discontinues orders for restorative treatment. RA #8 indicated she had discontinued treatment when Resident #13 was hospitalized on 3/18/14.</p> <p>During review of Resident #13's physician orders on 3/25/14 at 10:35 a.m., the physician order for a splint to the right hand was in place, and had not been discontinued. Resident #13 also had a quarterly activity review, dated 3/22/14, which indicated splints were to be placed on the right hand. Review of the most recent care plan, dated 3/26/14, indicated Resident #13 would exhibit improved right hand digit extension thru splinting to prevent further contracture and skin breakdown.</p> <p>On 3/28/14 at 1:30 p.m., the DoN indicated being unable to provide a specific policy in regards to following care plans and physician orders for treatments.</p> <p>3.1-42(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
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. Based on observation, interview, and record review, the facility failed to ensure denture tablets were secured in 6 of 14 resident rooms on the 100 hall, 1 of 2 medication carts was locked, and skin cleanser was secured in the dining room activity cabinet. This failure had the potential to effect 15 confused residents of 40 residents in the facility, including 1 resident (#34) who wandered at night. (Rooms 105,106,107,110,111, and 112)</p> <p>Findings Include:</p> <p>1. During a resident observation on 3/25/14 at 8:35 a.m., two cups of denture cleaner tablets were observed in the bathroom. The plastic drinking cup contained six denture cleaning tablets with the resident's name on the outside of the cup.</p> <p>Further observations, on 3/25/14 at 8:37 a.m., indicated cups in bathrooms containing denture tablets</p>	F000323	<p>F323</p> <p>1. The denture tablets were removed from the resident rooms 105, 106, 107, 110, 111, and 112. The Skin cleanser that was located in the unlocked cabinet in the dining room was removed. The medication carts were observed and were found locked and secured. Resident #34 was not affected by the unsecured items. The staff were re-educated on the proper storage of items that may be considered dangerous or hazardous to residents.</p> <p>2. All resident rooms and other resident areas were observed and any items that could be considered hazardous were removed. The staff were re-educated on the proper storage of items that may be considered dangerous or hazardous to residents.</p> <p>3. All staff have been re-educated on the storage and security of potentially hazardous items in resident areas throughout the facility. The Administrator and/or designee will monitor the resident rooms and other resident areas throughout the facility 5 xs weekly x 1 month then weekly thereafter to ensure the areas are</p>	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>in rooms 105,106,107,110,111, and 112.</p> <p>On 3/26/14 at 8:30 a.m., observations indicated plastic drinking cups with resident names filled with denture tablets were in the bathrooms of rooms 105,106 107, 110, 111, and 112.</p> <p>LPN #7 was interviewed on 3/26/14 at 2:15 p.m. During the interview, LPN #7 indicated a supply of denture cleaning tablets were located in the supply room. LPN # 7 indicated the Certified Nursing Assistants got the denture tablets from the supply room and took them to the resident rooms.</p> <p>CNA # 6 was interviewed on 3/26/14 at 2:20 p.m. During the interview, CNA #6 indicated the staff took denture cleanser tablets from the supply room stock to keep the plastic drinking cups with the resident's name on them in the bathrooms full of denture cleaning tablets.</p> <p>The nurse consultant was interviewed on 3/27/14 at 7:40 a.m. During the interview, the Nurse Consultant indicated she was not aware denture tablets were hazardous.</p> <p>The Denture Cleansing Tablet</p>		<p>free of potentially hazardous items are secured appropriately. Should concerns be observed, corrective action shall be taken.</p> <p>4. The Administrator and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Material Data Sheet (MSDS) dated November 4, 2003 was presented by the Nurse Consultant on 3/28/14 at 1:00 p.m. The MSDS sheet indicated, "...Can cause eye irritation....Expected to be slightly toxic by ingestion. If swallowed, do not induce vomiting: give large amounts of water or milk to dilute ingested material. CALL POISON CONTROL CENTER...".</p> <p>2. The noon meal was observed on 3/24/14. Ten residents were observed in the dining room, with no staff present, from 11:15 a.m. to 11:25 a.m.</p> <p>On 3/25/14 at 3:25 p.m., a plastic bottle labeled, "Foaming No Rinse Skin Cleanser" was observed in the unlocked Activity Cupboard in the facility dining room. The bottle indicated "Keep out of reach of children".</p> <p>The Activity Director (AD) was interviewed on 3/25/14 at 3:30 p.m. During the interview, the AD indicated she did not know how long the cleanser had been in the cupboard. She indicated one of her assistants must have put it there.</p> <p>3. On 3/26/14 at 12:00 p.m. two</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>medication carts were observed in the facility main hallway. One of the two medication carts was found to be unlocked. There were no staff observed in the area.</p> <p>The Nurse Consultant was interviewed on 3/27/14 at 7:40 a.m. During the interview, the Nurse Consultant indicated the medication cart should have been locked while unattended.</p> <p>The Director of Nursing (DoN) was interviewed on 3/28/14 at 9:30 a.m. During the interview, the DoN indicated the nurse should have locked the medication cart when she left it unattended to go the dining room.</p> <p>3.1-45(a)(1)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure bottles of medications, vials of medications and medication</p>	F000431	F431 1. The outdated Docusate Sodium, the unlabeled Lidoderm patches, and the outdated Albuteral Sulfate inhalation Solution were	04/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014	
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>patches were properly labeled and disposed of following expiration dates for 1 of 2 medication carts and 1 of 1 respiratory treatment carts observed. (100 hall medication cart and respiratory treatment cart)</p> <p>Findings include:</p> <p>1. During an observation of medication storage with the Assistant Director of Nursing (ADoN) on 3/27/14 at 10:30 a.m., the medication cart on the 100 Hall contained a bottle of Docusate Sodium (a medication used to treat constipation) 50 milligrams/5 milliliters with a dispense amount of 300 milliliters, a dispense date of 2/14/2013 and an open date of 2/25/13. The medication had 100 milliliters remaining in the bottle and no visible expiration date.</p> <p>The cart also contained nine unlabeled Lidoderm lidocaine patches 5% (a topical anesthetic) 700 milligrams (50 milligrams per gram adhesive) in an aqueous base. Each patch was 10 centimeters by 14 centimeters.</p> <p>During an interview with the Nurse Consultant on 3/27/14 at 11:25 a.m., she indicated she spoke with the</p>		<p>removed from medication carts, and destroyed according to facility procedures.</p> <p>2. All medication, respiratory and treatment carts were audited for any outdated and/or expired medications, with no further findings. Licensed Nursing staff was re-educated concerning checking to assure medications and treatments are labeled and not expired.</p> <p>3. The DON and/or designee will check medication, respiratory and treatment carts 3 xs weekly x 1 month then weekly thereafter to assure medications are correctly labeled and not expired. Any findings will be immediately corrected.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>pharmacy and the bottle of Docusate Sodium was expired since 2/14/14 and would have expired a year from the dispense date of 2/14/13.</p> <p>During an interview with LPN #5 on 3/27/14 at 11:30 a.m., she indicated she was unsure whose Lidoderm lidocaine patches were in the 100 medication cart since the patches were not labeled in any way.</p> <p>2. During an observation of medication storage with LPN #10 on 3/27/14 at 12:02 p.m., the bottom drawer of the respiratory medication cart contained a package of Albuterol Sulfate Inhalation Solution (inhalation solution used for relief of bronchospasm) 0.083% 2.5 milligrams/3 milliliters. A total of three 3 milliliter sterile unit dose vials had an expiration date of 08/12. The same package contained a 3 milliliter sterile unit dose vial of Albuterol and Ipratropium Inhalation Solution (used to treat chronic obstructive pulmonary disease) with an expiration date of 2/14.</p> <p>During an interview with LPN #10 at 3/27/14 at 12:25 p.m., she indicated the resident no longer had a breathing treatment ordered and was unsure of when it was discontinued.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>During an interview with Respiratory Therapist #2 on 3/27/14 at 12:28 p.m., she stated "It's all of our responsibility to make sure that medications are not expired and we will have to make a method to routinely check the medication carts. ...We go through the respiratory cart once a week when we order medications but we never look at the bottom drawer because we don't use the bottom drawer but we will now."</p> <p>Review of a current undated facility policy, titled "Storing Drugs", which was provided by the Corporate Nurse on 3/27/14 at 12:20 p.m., indicated the following:</p> <p>"Procedures</p> <ol style="list-style-type: none"> 1. The pharmacy supplier must dispense drugs in containers... Each drug must be kept and stored in the labeled dispensing container. Drugs may not be transferred from one container to another. This may be done only by a pharmacist.... 12. Any outdated, contaminated, or deteriorated drugs, or those in containers which are cracked, soiled, or without secure closures must be removed from stock and destroyed 			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	according to procedures for drug destructions." 3.1-25(o)			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F000441	<p>F441</p> <p>1. 1. The February Infection</p>	04/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
			<p>Control monitoring tracking was completed immediately. DON was re-educated to assure proper infection monitoring completed on a timely basis. 2. RN #3 and LPN #5 were re-educated on the proper procedure for dining room infection control and food handling. Residents # 13 and 23 had no negative outcomes. 3. Activity Assistant #11 was re-educated on proper glove use and hand washing during activities. Residents #20, 9, 39, 36,37,15,48, and 32 had no negative outcomes. 4. All disinfectant wipes were checked for expiration dates.</p> <p>2. The DON was re-educated to assure proper infection monitoring completed in an ongoing basis with summary completed on a monthly basis. All staff re-educated concerning hand washing, proper use of gloves, and food handling in the dining room and during activities. The Licensed nursing staff was re-educated to assure disinfectant wipes were not out dated.</p> <p>3. All staff was re-educated on hand washing with return demonstration. All staff was re-educated on dining room infection control including hand washing, glove use and proper food handling. The DON and/or designee (Administrative staff) will monitor 2 meals per day on scheduled work day's xs one month, 1 meal per day on scheduled work days for 1 month, than 1 meal per week</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
			<p>ongoing to assure proper dining room infection control including hand washing, glove use and proper food handling. The DON and or designee will monitor the disinfectant wipes 3 x per week x 1 month then weekly thereafter to ensure replaced if outdated. Should concerns be noted/observed, corrective action shall be taken.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and</p>	F000441	<p>F441</p> <p>1. 1. The February Infection</p>	04/27/2014
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>record review, the facility failed to ensure proper infection control practices were followed, in regard to the maintenance of an up to date tracking sheet for facility infections, hand washing, glove use, and the disinfection of reusable equipment. This deficiency had the potential to affect 40 of 40 residents residing in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an interview with the Director of Nursing (DoN) on 3/26/14 at 1:30 p.m., the DoN was unable to provide an up to date infection control tracking sheet for the month of February. The tracking sheet monitored infections within the facility on a monthly basis. 2. During an observation on 3/24/14 at 11:59 a.m., RN #3 was observed passing lunch trays in the main dining room, while touching unidentified residents with her hands. RN #3 continued to pass additional lunch trays until 12:06 p.m., without doing any hand washing. <p>During an additional observation on 3/24/14 at 12:01 p.m., LPN #5 was observed passing lunch trays in the</p>		<p>Control monitoring tracking was completed immediately. DON was re-educated to assure proper infection monitoring completed on a timely basis. 2. RN #3 and LPN #5 were re-educated on the proper procedure for dining room infection control and food handling. Residents # 13 and 23 had no negative outcomes. 3. Activity Assistant #11 was re-educated on proper glove use and hand washing during activities. Residents #20, 9, 39, 36,37,15,48, and 32 had no negative outcomes. 4. All disinfectant wipes were checked for expiration dates.</p> <ol style="list-style-type: none"> 2. The DON was re-educated to assure proper infection monitoring completed in an ongoing basis with summary completed on a monthly basis. All staff re-educated concerning hand washing, proper use of gloves, and food handling in the dining room and during activities. The Licensed nursing staff was re-educated to assure disinfectant wipes were not out dated. 3. All staff was re-educated on hand washing with return demonstration. All staff was re-educated on dining room infection control including hand washing, glove use and proper food handling. The DON and/or designee (Administrative staff) will monitor 2 meals per day on scheduled work day's xs one month, 1 meal per day on scheduled work days for 1 month, than 1 meal per week 	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>dining room, touching unidentified residents, and without washing or donning gloves, removed bread from the tray of Resident #13. LPN #5 buttered the bread, then assisted Resident #13 with removal of a sweater. LPN #5 then removed the bread from Resident #23's tray, and without washing or donning gloves, buttered the bread and continued passing lunch trays until 12:10 p.m. During an interview on 3/26/14, at 1:30 p.m., the DoN indicated staff was expected to always wash hands before and after any resident contact.</p> <p>3. The noon meal was observed on 3/24/14. At 11:25 a.m., Activity Assistant #11 entered the facility dining room. The assistant was wearing disposable gloves and carrying a bottle of lotion and bottle of hand sanitizing gel.</p> <p>Beginning with Resident #20, the assistant went from table to table and applied lotion to Resident #'s 9, 39, 36, 37, 15, 48, and 32, never removing the gloves or washing her hands.</p> <p>The Activity Assistant #11 was interviewed on 3/27/14 at 1:00 p.m. The assistant indicated she had been</p>		<p>ongoing to assure proper dining room infection control including hand washing, glove use and proper food handling. The DON and or designee will monitor the disinfectant wipes 3 x per week x 1 month then weekly thereafter to ensure replaced if outdated. Should concerns be noted/observed, corrective action shall be taken.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 4-27-14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>working in the Activity Department and doing hand massages for a couple of years.</p> <p>4. During an observation on 3/26/14 at 2:30 p.m., LPN #7 was asked to produce the type of disinfectant wipe used to clean glucometers between resident use. The disinfectant wipes produced by LPN #7, had an expiration date of 11/2013. At this same time, RN #9 was asked to produce the type of disinfectant wipes used to clean glucometers between resident use. The wipes RN #9 produced were also expired 11/2013. LPN #7, and RN #9 discarded the expired wipes and produced replacement wipes with an expiration date of 6/2014.</p> <p>A policy provided by the DoN on 3/28/14 at 1:10 p.m., titled "Fundamentals of Standard and Transmission Based Precautions" indicated the following: "Standard precautions are work practices that provide a basic level of infection control for the care of all patients in healthcare facilities regardless of their diagnosis or presumed infection status. They</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	include: Good hygiene practices, particularly washing hands before and after patient contact and the use of protective barriers, which may include gloves...." 3.1-18(j) 3.1-18(l)			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement appropriate plans of action to address a behavior management plan, the development and implementation of careplans, following the care plans, monitoring of infection control practices, maintaining nutritional status, freedom from hazardous chemicals, and quality assurance. These deficiencies had the potential to</p>	F000520	<p>F520</p> <p>1. Corrective actions as described in the Plan of Correction were taken for all residents relative to concerns of: Behavior management plan that documented resident behaviors; developing resident care plans, and then implement those plans of care; providing resident care for pressure ulcers to promote the highest well being, monitoring infection control practices to prevent the spread of infections; maintenance of residents</p>	04/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>affect 40 of 40 residents residing in the facility.</p> <p>Findings include:</p> <p>The Administrator was interviewed on 3/28/14 at 2:15 p.m. The Administrator was queried regarding the facility QAA (Quality Assurance and Assessment) and the identified concerns of the Annual Recertification Survey as follows:</p> <ol style="list-style-type: none"> 1. A behavior management plan that documented resident behaviors. 2. Developing resident care plans, and then implementing those plans of care. 3. Providing residents care for pressure ulcers to promote the highest well being. 4. Monitoring infection control practices to prevent the spread of infections. 5. Maintenance of resident nutritional status. 6. Freedom from hazardous chemicals. 7. Quality assurance <p>The Administrator indicated these concerns had not been included in the facility QAA program.</p> <p>3.1. 1-52(b)(2)</p>		<p>nutritional status and freedom from hazardous chemicals.</p> <p>2. As all residents could be affected, the following corrective actions have been taken. Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not limited to Behavior management plan that documents resident behaviors, developing resident care plans and then implementing those plans of care, providing residents care for pressure ulcers to promote the highest well being, monitoring infection control practices to prevent the spread of infections, maintenance of residents' nutritional status and freedom from hazardous chemicals.</p> <p>3. Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not limited to Behavior management plan that documented resident behaviors, developing resident care plans, and then implementing those plans of care, providing resident care for pressure ulcers to promote the highest well being, monitoring infection control practices to prevent the spread of infections, maintenance of residents nutritional status and Freedom from hazardous chemicals. Administrator and/or Administrative Nursing shall be responsible to conduct and/or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
			<p>delegate said audits in an effort to identify quality of care areas of concern and address with the Quality Assurance Committee in an effort to formulate an action plan, should deficient practice be identified.</p> <p>4. As a means of Quality Assurance, The Administrator and/or designee, the DON and/or designee shall report findings of aforementioned audits and immediate corrective actions taken to the QAA Committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next QA meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of actions to correct identified quality deficiencies.</p> <p>5. 4-27-14</p>		