

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
---	---

(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
F0000	<p>This visit was for the Investigation of Complaint IN00104374.</p> <p>Complaint IN00104374 -- Substantiated. Federal/State deficiency related to the allegations is cited at F328.</p> <p>Survey dates: March 14 and 15, 2012</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 30 SNF/NF: 26 Residential: 34 Total: 90</p> <p>Census payor type: Medicare: 18 Medicaid: 23 Other: 49 Total: 90</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction does not constitute an admission by Glen Oaks Health Campus of any wrong-doing or failure to comply with Federal or State regulations. Moreover, the allegations contained in this statement of deficiency are not a true or accurate portrayal of the provision of nursing care or the services of this facility. The provider wishes this plan of correction be considered as our allegation of compliance. The provider respectfully requests a desk review with paper compliance be considered in establishing the provider is in substantial 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: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 3/16/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to ensure the physician ordered oxygen delivery rate was followed for 1 of 3 residents reviewed for oxygen therapy in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 3-14-12 at 11:01 a.m. His diagnoses included, but were not limited to COPD (chronic obstructive pulmonary disease or lung problems), pneumonia (Jan. 2012), congestive heart failure, high blood pressure, coronary artery disease (heart problems), gout, prostate cancer, rheumatoid arthritis and osteoarthritis.</p> <p>Review of the resident's admission orders, dated 1-13-12, indicated the attending physician had ordered for resident A to receive oxygen at 3 liters per minute</p>	F0328	<p>1)Resident A was discharged from Glen Oaks Health Campus on February 24, 2012.2)All residents receiving oxygen have the potential to be affected by the same alleged deficient practice. The facility compiled a list of all residents on oxygen 3/16/2012. Oxygen flow rates were confirmed to be set at the flow rate ordered by the physician.3)The campus will review the following guidelines by 3/30/2012. They include: Guidelines for Administration of OxygenGuidelines for Medication Orders4)The campus Director of Health Services or designee monitors new medication orders five times weekly. Periodic monitoring and auditing of oxygen administration will increase through 5/15/2012 based on the following audit schedule:Oxygen Administration Audits will be completed 5 times weekly through 4/15/2012.Oxygen Administration Audits will be</p>	03/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362		
(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	
	(LPM) via (through a) nasal canula continuously. Review of the nursing notes indicated resident A was receiving this oxygen rate from admission through 1-27-12. On 1-28-12 at 7:00 p.m., the resident had shortness of breath and difficulty breathing. The nursing notes indicated the oxygen rate was increased to 4 LPM. The physician was made aware of the situation and the family was present and aware of the situation. The resident continued to be monitored and the following day, 1-29-12 at 4:00 p.m., the resident experienced a similar event. The nursing notes indicated he remained on 4 LPM of oxygen. The physician was again notified of the situation and ordered for him to be sent to an area emergency room for evaluation. Nursing notes indicated he was transported to the area emergency room at 7:30 p.m. Nursing notes indicated the resident returned to the facility approximately 4 hours later on 1-30-12 at midnight with the oxygen rate at 3 LPM. Nursing notes on 1-30-12 at 6:30 p.m. indicated the oxygen rate was at 4 LPM. Nursing notes indicated from this date, 1-28-12 through 2-10-12, the oxygen rate remained at 4 LPM. From 2-10-12 through 2-16-12 the oxygen rate was indicated as 4 LPM. On 2-17-12 the oxygen rate was indicated as 2 to 3 LPM. On 2-18-12 to 2-22-12, the oxygen rate was indicated as 4 LPM. On 2-23-12, the		completed 3 times weekly through 4/30/2012. Oxygen Administration Audits will be completed 2 times weekly through 5/15/2012. The Director of Health Services or designee will complete the audits and forward audit results to the Quality Assurance and Assessment Committee for further review.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
---	---

(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>nursing notes indicated he was receiving oxygen therapy, but did not indicate the rate.</p> <p>In interview with the Assistant Director of Nursing on 3-14-12 at 2:01 p.m., she indicated there should be a physician order for the oxygen rate. She indicated that as a nursing measure, the oxygen rate can be increased for a 24 hour time period, but after that, a physician's order should be obtained to continue it at the increased rate. She indicated Resident #A had been sent out to the emergency room around the time of the oxygen rate increase. She indicated she could not find any physician order to indicate to change the oxygen rate upon return to the facility, so she would assume the oxygen rate should have returned to the 3 LPM as it had been previously.</p> <p>In interview with RN #1 on 3-15-12 at 10:50 a.m., she indicated she recalled Resident #A had oxygen in use at the rate of 4 LPM. In interview with CNA #2 on 3-15-12 at 10:40 a.m., she indicated she recalled Resident #A initially had oxygen at a rate of 3 LPM, but it was increased to 4 LPM.</p> <p>In interview with a family member on 3-14-12 at 10:18 a.m., the family member indicated Resident #A was on oxygen at a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
---	---

(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>rate of 4 LPM.</p> <p>A policy entitled, "Guidelines For Administration Of Oxygen," was provided by the Assistant Director of Nursing on 3-14-12 at 2:35 p.m. She identified this policy as the current policy in use. The policy indicated the purpose of the policy was, "To provide guidelines for safe oxygen administration when insufficient oxygen is being carried by the blood to the tissues...1. Verify physician's order for the procedure. 2. In cases of emergency [sic] oxygen may be administered as a nursing intervention until a physician's order may be obtained."</p> <p>This Federal tag relates to Complaint IN00104374.</p> <p>3.1-47(a)(6)</p>			
--	---	--	--	--