STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN47203	

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 12, 13, 14, 15, and 16, 2011 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Survey team: Diana Sidell RN, TC Cheryl Fielden RN Penny Marlatt RN (December 12, 13, 14, and 15) Janie Faulkner RN (December 15 and 16) Census bed type: SNF: 46 SNF/NF: 24 Residential: 32 Total: 102 Census payor type: Medicare: 27 Medicaid: 18 Other: 57 Total: 102 Sample: 15 Supplemental sample: 1 Residential sample: 7	F0000	Submission of this plan of correction and credible allegations does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. Please accept this plan as same and our credible allegation of compliance. Silver Oaks health Campus submits this plan of correction as it's letter of credible allegation and requests a desk review if possible. We are alleging our cmpliance on 01/14/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 12/21/11 by Suzanne Williams, RN			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain the temperature of the milk in the main dining room at a safe temperature prior to serving, during 2 of 2 meal observations, and failed to ensure appropriate head coverings for all persons in the dietary food preparation areas during 2 random observations and 1 of 2 meal observations. These deficient practices have the potential to adversely affect 40 residents served food from the dietary food service area of 45 residents in the certified area of the facility. Findings include: 1. During a lunch time dining observation on 12-12-11 at 11:49 a.m., 3 milk jugs were observed to be sitting on top of a pan of ice in the main dining room, prior to the commencement of serving lunch. The dietary staff was requested to verify the	F0371	1.)1.) DFS switched to smaller caraffes to enable make it more feasible to maintaing milk temperature.2.) Facility to Purchase a small refrigerator to store milk in dining room to maintain constant milk temps during meal service.3. DFS to Inservice Dining Staff related to caraffes and proper set up techniques.4. DFS or Designee will audt milk temps 2 x day 5 days a week x 2 weeks, then 3 x week x 4 weeks, then monthly x 3 and quarterly x 4.5. Audits will be reveiwed monthly in QA x 3 months and then Quarterly x 4. 2.)1. Purchase Holders for hairnets to make more readily accesible to staff, before entering the Kitchen.2. Inservice all staff related to hairnets in the Kitchen.3. Monitor wearing of hairnets 2 x day 5 days a week x 2 weeks then 3 x week for 4	01/14/2012

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	milk temperatures prior to serving of the milk at this time. Dietary Staff #1 was observed to check the temperatures of the milk as follows: whole milk at 48 degrees, 2% milk at 50 degrees and chocolate milk at 50 degrees. Dietary Staff #1 discarded these 3 jugs of milk and obtained new milk from the walk-in refrigerator. Dietary Staff #1 was observed at 11:55 a.m. to verify the temperature of the newly obtained milk products as follows: whole milk at 40 degrees, 2% milk at 40 degrees and chocolate milk at 42 degrees. The jugs of milk were observed to be placed into the tray of ice, prior to the lunch meal service. 2. During a supper time dining observation on 12-13-11 at 4:40 p.m., 3 milk jugs were observed to be sitting on top of a pan of ice in the main dining room, prior to the commencement of serving supper. The dietary staff was requested to verify the milk temperatures prior to serving of the milk at this time. The Dining Services Manager (DSM) was observed to check the temperatures of the milk as follows: whole milk at 50 degrees, 2% milk at 46 degrees and chocolate milk at 48 degrees. The DSM discarded these 3 jugs of milk and obtained new from the walk-in refrigerator. The DSM was observed at 4:45 p.m. to verify the temperature of the		weeks then monthly x 3 then quarterly x 4 .4. This will be monitored through QA monthly x3 then Quarterly x 4.	

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	newly obtained milk products as follows: whole milk at 42 degrees, 2% milk at 42 degrees and chocolate milk at 40 degrees. The jugs of milk were observed to be placed into the tray of ice, prior to the supper meal service. Review of the "Food Temperature Log" for October, November and December, 2011, provided by the Executive Director on 12-14-11 at 11:40 a.m., indicated the milk temperatures before each meal ranged from 34 to 36 degrees, with one exception, which was 42 degrees on 12-12-11 for the lunch meal. Review of a document entitled, "Residents [sic] Milk w/ [with] Meals," was provided by the Executive Director on 12-14-11 at 11:40 a.m. This document indicated the current number of residents who requested milk with meals as follows: 2 residents requested whole milk with lunch and supper; 9 residents requested chocolate milk with lunch and supper and no residents requested 2% milk for lunch and supper. In interview with the DSM on 12-13-11 at 4:45 p.m., he indicated he would get the temperature problem resolved as quickly as possible. 3. During a random dietary observation			

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	on 12-12-11 at 1:05 p.m., LPN #3 was observed in the dietary area, standing near the dishwashing area without a head covering. This area was near the entry way from the main dining area in the dietary area. At this time, the dietary staff was actively in the process of cleaning up from the lunch dining service and using the dishwasher. During a random dietary observation on 12-13-11 at 4:20 p.m., Receptionist #4 was observed standing in the equipment storage area, near an ice-cream freezer without a head covering. This area was near the entry way from the assisted living dining area in the dietary area. At this time, the dietary staff was actively preparing for the supper meal service. During a dietary observation on 12-13-11 at 4:50 p.m., Dietary Staff #2 was observed preparing resident's supper meal at the steam table in the dietary area. She was observed to be wearing a hair net with at least one inch of hair uncovered in the front with tendrils of hair near the ears uncovered and approximately 3 inches of hair uncovered in the back portion of her head. Dietary Staff #2 was observed to cover her hair with a hair net after speaking with the DSM at 4:48 p.m. In interview with the DSM on 12-13-11 at			

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	4:57 p.m., he indicated he had previous discussions with other dietary managers in regards to head coverings in the dietary area. He indicated there had been discussions about "safe zones in the kitchen area" in which it was thought one might not need to wear a head covering, such as near the doors from the main dining room and the assisted-living dining room. He indicated he "would prefer anyone coming into the kitchen to wear a hair net or head covering." A policy entitled, "Food Temperatures - Serving Line," with an annual review date of 11/11/11, was provided by the Social Services Designee (SSD) on 12-14-11 at 10:12 a.m. This policy indicated, "...Cold foods are maintained and served at 41 [degrees] F [Fahrenheit] or less. Temperatures are taken prior to service to ensure hot foods and cold foods are maintained at the above temperatures. Temperatures are recorded on the Steam table Temperature form and kept on file for 1 year..." A policy entitled, "Dress Code and Uniform Standards," with an annual review date of 11-11-11, was provided by the SSD on 12-14-11 at 10:12 a.m. This policy indicated, "...Dining Services employees must wear a hair restraint or approved hat while serving food and in			

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	food preparation areas..." Another policy, entitled "Dining Services Dress Code," provided at the same time by the SSD, indicated as an action to conduct is, "...Hair restraint worn in the kitchen..." In interview with the Executive Director on 12-14-11 at 11:05 a.m., she indicated, "we don't have a specific policy about other staff being in the kitchen. The policy on head coverings for the dietary staff applies to everyone [that would be in the dietary area]." 3.1-21(i)(3)			
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review, the facility failed to ensure timeliness of physician visits for 1 of 13 residents reviewed for timeliness of physician visits in a sample of 15. (Resident #67) Findings include: Resident #67's clinical record was reviewed on 12-12-11 at 2:07 p.m. Her diagnoses included, but were not limited	F0387	1. Resident # 67 has been discharged from facility.2. Audits completed on all residents by DHS or Degsinee to ensure no other residents were affected by deficiency.3. Certified Letter to be sent to Physicians that follow residents at facility to remind them of timeliness of physician visits and that Medical Director will see Residents if Attending Physician is unable to see resident.4. Audits to be completed by DHS or Desginee	01/14/2012

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	to, toxic metabolic encephalopathy of a multifocal nature, aspiration pneumonia, urinary tract infection, bilateral humerus (upper arm) fractures, high blood pressure, Alzheimer's dementia and anxiety. Resident #67 was admitted to the facility originally on 9-11-11 and readmitted on 9-27-11, after a hospitalization. Review of the attending physician's visits with the resident indicated the most recent visit was on 11-1-11. This date indicates it more than 30 days between the previous visit on 9-14-11 and more than 30 days since the most recent visit was conducted. In interview with the Executive Director (ED) on 12-13-11 at 11:27 a.m., she indicated Resident #67 had not been seen by the attending physician since 11-1-11, but was scheduled for an appointment with him on 12-19-11. A policy entitled, "Guidelines for Physician Services," with an annual review date of 11-11-11, was provided by the ED on 12-14-11 at 8:05 a.m. This policy indicated, "...Physician visits, frequency of visits...are provided in accordance with current OBRA regulations and campus policy." A policy entitled, "Physician Visit		weekly x 4 weeks then monthly x 3, then quarterly x4.5. Audits to be monitored monthly in QA x 3 months then Quarterly x 3.	

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	Notification," with an annual review date of 11-11-11, was provided by the ED on 12-14-11 at 9:50 a.m. This policy indicated, "It is the policy of [name of facility] to comply with the Indiana State Board of Health Regulations [sic] that physicians visit and write a progress note every 30 days for the first 90 days of a resident's stay and then every 60 days during the residents [sic] stay in our facility." 3.1-22(d)(1) 3.1-22(d)(2)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. A. Based on observation, interview, and record review, the facility failed to ensure accurate administration of medication in that a newly opened multidose inhaler was	F0425	1.)1. Inservice nursing staff related to proper administration of multidose inhaler completed by DHS or Desginee. 2. All Nurses	01/14/2012

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	not primed before the first use for 1 of 1 resident in 8 residents observed during 1 of 3 medication administration observations. (Resident #69) B. Based on record review and interview, the facility failed to provide pharmaceutical services that included the disposition of medications in that 2 discharged residents lacked documentation of disposition of medications. This affected 2 of 2 residents reviewed for disposition of medications in a sample of 15. (Residents # 72 and 73) Findings include: A. During a medication administration observation on 12/13/11, beginning at 9:03 a.m., LPN #7 was observed as he administered Flovent 220 micrograms, an inhalation medication, to Resident #69. LPN #7 removed the inhaler from an unopened package and shook the inhaler before administering it to Resident #69. LPN #7 was not observed to prime the inhaler before administering the first dose of medication. When queried if he had primed the inhaler, LPN #7 indicated he did not prime it. The number on the inhaler's counter after the medication administration was observed to be 123.		and QMA's to watch Med-Pass video.3. DHS or Designee will monitor Med Pass 3 x week x 2 weeks then weekly x 3 weeks then monthly x 3 then quarterly x 3.4. Monitoring of Med Pass will be reviewed monthly in QA x 3 then Quarterly x 3. 2.)1. New Drug Disposition Form Implemented immediately. 2. DHS or Degsinee to inservice nursing staff related to Drug Disposition Form.3. DHS or Designee to audit drug disposition forms weekly x 3 weeks then monthly x 3 weeks then quarterly x 3 weeks. 4. Auditing of Drug Disposition sheets will be monitored in QA monthly x3 then Quarterly x 3 months.	

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	The package insert for the Flovent inhaler was provided by the Director of Health Services on 12/13/11 at 10:57 a.m. The insert included, but was not limited to, "...Priming the inhaler: Before you use Flovent HFA for the first time, you must prime the inhaler so that you will get the right amount of medicine when you use it. To prime the inhaler, take the cap off the mouthpiece and shake the inhaler well for 5 seconds. Then spray the inhaler into the air away from your face. Avoid spraying in eyes. Shake and spray the inhaler like this 3 more times to finish priming it. The counter should now read 120...." B. 1. Resident #72's closed record was reviewed on 12/15/11 at 10:56 a.m. The record indicated Resident #72 was admitted with diagnoses that included, but were not limited to, altered mental status, difficulty walking, muscle weakness, dizziness, diabetes mellitus, and high blood pressure. Discharge instructions dated 9/30/11 indicated Resident #72 was receiving the following medications upon discharge: Nitrofurantoin 50 mg (milligrams) by mouth at bedtime daily. Losartan-Hydrochlorothiazide 100/25 mg by mouth daily Humulin 70/30 6 units injection every day Tylenol 500 mg every 6 hours as needed			

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	Namenda 10 mg by mouth twice a day Milk of magnesia 30 milliliters by mouth daily as needed Dulcolax 10 suppository daily as needed Plavix 75 mg by mouth daily Amlodipine 10 mg by mouth daily ASA 81 mg by mouth daily Calcium carbonate 500 mg by mouth daily Cyanocobalamin (Vitamin B supplement) 1 mg by mouth daily Calcium with Vitamin D by mouth daily No documentation was in the closed record that indicated the method of drug disposition of these medications. During an interview on 12/15/11 at 12:40 p.m., the Executive Director indicated their pharmacy consultant said they didn't have to fill out the form they used for medication returns anymore, so they stopped using that form, and they haven't been using any form. B. 2. Resident #73' s closed record was reviewed on 12/15/2011 at 12:30 p.m. The record indicated Resident #73 was admitted with diagnoses that included, but were not limited to, chronic pain, GERD (gastroesophageal reflux disease), HRT (hormone replacement therapy), constipation, muscle spasms, post surgical hip repair, and cholesterolemia.			

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	Discharge instructions dated 10/4/11 indicated Resident #73 was receiving the following medications upon discharge: Colace 100 mg (milligrams) by mouth twice a day. Niferex 150 mg by mouth twice a day. Vitamin C by mouth twice a day. Ultram 50 mg by mouth every 6 hours. Multivitamin by mouth once a day. Glucosamine 500 mg by mouth once a day. Premavin 0.3 mg by mouth once a day. Simvastatin 80 mg by mouth once a day. Calcium 600 mg by mouth once a day. Miralax, mix with orange juice by mouth once a day. Valium 5 mg by mouth once a day. Claratin 10 mg by mouth once a day. Coumadin 2.5 mg by mouth once a day. Coumadin 2 mg by mouth once a day. No documentation was in the record that indicated the method of drug disposition of these medications. A policy and procedure for "Disposal of medications and medication-related supplies" with a last review date of 11/11/11 was provided by the Executive Director on 12/14/11 at 2:55 p.m. The policy included, but was not limited to, "...Discontinued medications and medications left in the facility after a			

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	resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed...E. The nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the medication disposition form...1) Date of destruction 2) Resident's name 3) Name and strength of medication 4) Prescription number 5) Amount of medication destroyed 6) Signatures of witnesses. F. The medication disposition form is kept on file in the facility for two years or five years for narcotics...." 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)			

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F0441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure routine and appropriate hand washing in that during a medication pass observation, LPN #5 was observed using a glucose	F0441	1. Inservice all nursing staff related to proper Handwashing.2. All nursing staff to watch med pass video.3. DHS or Desginee to audit med pass 3 x week x 2 weeks, weekly x 3, monthly x 3	01/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2011
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	monitoring machine on one resident and administering medications to 3 residents without washing her hands between residents. This affected 3 of 8 residents observed during 1 of 3 medication administration observations. (Residents #3, 18, and 2) Findings include: During a medication pass observation on 12/13/11 at 8:13 a.m., LPN #5 was observed as she wore gloves and used a blood glucose meter to obtain a blood sugar level for Resident #3. After acquiring the blood sugar level, LPN #5 removed the gloves and did not wash her hands before preparing and administering the following medications for Resident #3: Prilosec OTC 20 mg (milligrams) 1 capsule, Baclofen 10 mg 1/2 tablet, Lisinopril 5 mg 1 tablet, Fenofibrate 200 mg 1 tablet, Vitamin C 500 mg 1 tablet, Multivitamin 1 tablet, and Valium 5 mg 1 tablet. LPN #5 next prepared Resident #18's medications and did not wash her hands prior to preparing and administering the following medications: Coreg 25 mg 1 tablet, Multivitamin 1 tablet, Digoxin 125 micrograms, Ferrous sulfate 325 mg 1 tablet, Folic acid 1 mg tablet, Lasix 20 mg 1 tablet, Glimepiride 4 mg 2 tablets,		then quarterly x 3. 4. Audits to be reviewed during QA monthly x 3 then quarterly x 3.	

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	Losartan 50 mg 1 tablet, Vitamin B complex with vitamin C 1 tablet, and Vitamin D 2000 IU (International units). Prior to administering the Digoxin, LPN #5 touched Resident #18's left wrist to obtain a pulse. LPN #5 then prepared Resident #2's medications and did not wash her hands prior to preparing and administering Baclofen 10 mg 1 tablet, Keppra 500 mg 1 tablet, Keppra 750 mg 1 tablet, Lisinopril 10 mg 1 tablet, Singulair 10 mg 1 tablet, Ferrex 150 mg 1 tablet, Senna plus 8.6 mg/50 mg, and Zoloft 100 mg 1 tablet. When queried on 12/13/11 at 8:45 a.m., LPN #5 indicated she did not wash her hands and stated "I should have". A policy and procedure for "Guidelines for Handwashing", with an annual review date of 11/11/11, was provided by the Executive Director on 12/14/11 at 8:05 a.m. The policy indicated, but was not limited to: "Purpose: Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF (Long Term Care Facilities). Implementation of PROPER handwashing practices has interrupted outbreaks in			

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	many settings. Procedure...3. Health Care Workers shall wash hands at times such as...b. Before/after having direct physical contact with residents. c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc...." 3.1-18(l)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to document administration of ordered medications by initialing the date and time on the MAR (medication administration record) and failed to document an explanation of why the medications were not given for 2 of 13 residents reviewed for complete and accurate records in a sample of 15. (Residents #31 and #43)	F0514	1. Inservice all nursing staff related to proper documentation related to Medication administration.2. DHS or Degsinee to audit med pass 3 x week x 2 weeks, then weekly x 3 then monthly x 3 then quarterly x 3.3. Audits to be reviewed in QA monthly x 3, Quarterly x 3.	01/14/2012

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	Findings include: 1. On 12/12/2011 at 1:40 p.m. review of Resident #31's most recent physician's recapped orders, dated 12/01/2011, indicated the following diagnoses: Post bilateral deep venous thrombosis with inferior vena cava filter (4/03), right post cerebral vascular accident, high blood pressure, congestive heart failure, hysterectomy, bilateral lower extremity edema, chronic pain, constipation, arthritis, history of shingles, status post left hip replacement, insomnia, and bilateral ankle pain. Record review indicated Resident #31 was receiving the following medications: Divalproex Sodium Sprinkles 250mg two times a day. Ibuprofen 400mg two times a day. Lorazepam 0.25mg every 8 hours. Polyethelene Glycol 17gm one time a day. Senna plus 8.6 mg two times a day. Seroquel 50mg two times a day. Promod 30cc two times a day. Review of resident #31's MARs dated 10/1/2011 through 10/31/2011 and 11/1/2011 through 11/30/2011 indicated the following:			

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	10/1/2011 through 10/31/2011 MAR: - Seroquel 50 mg tablet , 1 tablet orally 2 times a day for agitation/behavior as ordered on 12/31/09 - The 10/14 upon rising dose was blank. - Divalproex SOD SPK 125 mg, Give 2 capsules (250mg) orally twice a day for seizures as ordered on 7/29/10 - The 10/28 upon rising dose was blank. - Polyethylene Glyocol 3350 Miralax powder Mix 17gm (1 lidfull) in liquid and give orally every day for constipation as ordered on 3/22/2001 - The 10/29 upon rising dose was blank. 11/1/2011 through 11/30/2011 MARs: - Seroquel 50 mg tablet , 1 tablet orally 2 times a day for agitation/behavior as ordered 12/31/09 - The 11/18, 11/20, 11/21, 11/25, 11/28, 11/29, 11/30 upon rising doses were blank. - Divalproex SOD SPK 125mg give 2 capsules (250mg) orally twice a day for seizures as ordered 7/29/10 - The 11/25, 11/28, 11/29, 11/30 upon rising doses were blank, and the bedtime 11/18 dose was blank. - Ibuprofen 400 mg tablet give 1 tablet by mouth twice daily for arthritis as ordered			

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	12/12/08 - The 11/1, 11/25, 11/28, 11/29, 11/30 upon rising doses were blank. The bedtime 11/18, 11/23, 11/24 doses were blank. - Lorazepam intensol 2 mg/ml give 0.25 (0.5 mg) by mouth or under the tongue every 8HRS around the clock as ordered 7/1/11 - The 11/6, 11/23, 11/28 3pm doses were blank, the 10pm doses for 11/1, 11/18, 11/26, and 11/27 were blank. - Polyethylene Glyocol 3350 Miralax powder Mix 17gm (1 lidfull) in liquid and give orally every day for constipation as ordered 3/22/11 - The 11/21,11/25, 11/27, 11/28, 11/29, 11/30 upon rising doses were blank. - Senna Plus TAB 8.6/50 mg Senna-S Tablet, give 1 tablet by mouth BID for constipation as ordered 10/27/10 - The 11/18, 11/20, 11/21, 11/25, 11/28, 11/29, and 11/30 upon rising doses were blank. - Promod: 30cc orally twice daily for wound care as ordered 4/30/10 - The 11/18, 11/20, 11/21, 11/25, 11/28, 11/29, and 11/30 upon rising doses were blank, and the 11/18 bedtime dose was blank. 2. The record for Resident #43 was reviewed on 12/12/11 at 2:45 p.m. The			

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	record indicated Resident #43 was receiving the following medications: Atenolol 50 mg one time a day. Corocidin 1 tablet two times a day. Omeprazole 20 mg one time a day. Oyst-Cal 500 with Vitamin D one time a day. Polyethylene 17 gm one time a day. Warfarin 2.5 mg every Saturday and Sunday. Auquaphor ointment bilateral lower extremities two times a day. Fiber-Lax 625 mg 2 tablets two times a day. Hydrocodone APA 10/325 every 6 hours. Review of Resident #43's 11/1/2011 through 11/30/2011 2011 MARs indicated the following: - Atenolol 50 mg tablet give 1 tablet by mouth once a day for HTN as ordered on 6/30/09 - The 11/25, 11/28, 11/29,11/30 upon rising doses were blank. - Coricidin HBP Cough and cold give 1 tablet by mouth 2 times a day for antihistamine/decongestant as ordered on 6/30/09 - The 11/25, 1128, 11/29, 11/30 upon rising doses were blank. - Fiber-lax captabs Fibercon 625 mg			

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	caplet give 2 tablets by mouth twice a day for constipation as ordered on 6/3/09 - The 11/25, 11/28, 11/29, 11/30 upon rising doses were blank. - Hydrocodone/Apap 10/325 give tablet orally every 6 hours for pain as ordered on 10/2/09 - The 11/4 6 p.m., 11/25 12 p.m., 11/28 12 p.m., 11/29 12 p.m., 11/30 12 p.m. doses were blank. - Omeprazole 20 mg capsule give 1 capsule orally once daily for GERD as ordered 4/3/10 - The upon rising 11/25, 11/28, 11/29, 11/30 doses were not given. - OYST-CAL 500+D 200IU tab give 1 tablet orally once a day as supplement as ordered 6/30/09 - The upon rising 11/25, 11/28, 11/29, 11/30 doses were not given. - Polyethelene Glycol 3350 Miralax Powder Give 17 gm (1 lid full) in water or juice orally once a day for constipation as ordered on 6/30/09 - The upon rising 11/25, 11/28, 11/29, 11/30 doses were not given. No further documentation could be found in the nurse's notes or clinical record that explained the failed documentation of medications.			

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	On 12/13/2011 at 10:40 a.m., regarding the missing initials on the MAR and no documentation in the clinical record regarding the missing initials, the Director of Health Services indicated: "You are not going to find it." A policy and procedure titled "Preparation and General Guidelines" indicated: "If a dose of regularly scheduled medication is with held, refused, or given at other than scheduled time...the space provided on the front of the MAR for that dosage administration is (initialed and circled). An explanatory note is entered on the reverse side of the record provided for PRN documentation. If one dose of a vital medication are withheld or refused, the physician is notified." 3.1-50(a)(1) 3.1-50(a)(2)			
R0000	The following state residential findings are cited in accordance with 410 IAC 16.2-5.	R0000	Submission of this plan of correction and credible allegations does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility.	

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			Please accept this plan as same and our credible allegation of compliance. Silver Oaks health Campus submits this plan of correction as it's letter of credible allegation and requests a desk review if possible. We are alleging our cmpliance on 01/14/2012.	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review, the facility failed to assess a resident prior to admission for 1 of 7 residents reviewed for pre-admission evaluations in a sample of 7. (Resident #74) Findings include: Resident #74's record was reviewed on 12/15/11 at 10:48 a.m. The record indicated Resident #74 was admitted on 2/9/11 with diagnoses that included, but were not limited to, Alzheimer's disease, high blood pressure, and agitation. No pre-admission evaluation could be located in the resident's record. A policy for "Qualifying a Resident for Assisted Living/Pre admission	R0214	1. Resident #74 had no pre-admission evaluation in the record. Did have current plan of care, which included questions related to pre-admission evaluation.2. Audits competed on all Assisted Living residents by DHS.3. Facility will Audit all new referrals for pre-admission screening, to ensure all residents have pre-admission evaluations. 4. Continuing compliance will be maintained by auditing all new admission charts to ensure pre-admission evaluation is completed, this will be monitored through QA monthly x 3 months, and then quarterly x 4 months.5. Inservice CSR, CSS, and A.L. staff related to improtance of completing and having on chart pre-admission evaluation.	01/14/2012

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	Evaluation", with an annual review date of 11/11/11, was provided by the Director of Health Services on 12/15/11 at 12:38 p.m. The policy indicated: "Purpose: It is the policy of Trilogy Health Services to assess all residents prior to admission to our Assisted Living Residence. Procedure: Each resident shall receive an evaluation which shall be initiated prior to admission and updated at least semiannually and upon a known substantial change in resident's condition or more often at the resident's or facility's request. A licensed nurse shall evaluate the nursing needs of the resident. The preadmission evaluation (interview) shall provide the baseline information for the initial assessment. Subsequent evaluations shall compare the resident's current status to his status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. The evaluation shall include at least the following: 1) physical and mental status 2) independence in activities of daily living 3) resident's ability to self-administer medications, if applicable 4) weight on admission and semi-annually thereafter."			

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R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a resident had an evaluation for self administration of medications for 1 of 5 residents reviewed for self administration of medications in a sample of 7. (Resident #106) Findings include: Resident #106's record was reviewed on 12/15/11 at 9:30 a.m. The record indicated Resident #106 was admitted with diagnoses that included, but were not limited to, arthritis, anemia, high blood pressure, low potassium level, and lung problems. A service plan last reviewed on 9/20/11 indicated "...Medication and treatments: Assist with obtaining medications, Monitor self administration" and included	R0216	4. 1.) Nursing staff to complete Self Administration Assessment on Resident #106.2.) DHS or Designee will Audit all A.L. Charts to ensure no other residents affected by deficient practice.3.) DHS or Designee will inservice all A.L. Nursing staff related to completing Self Administation Assessment4.) Audits will be completed Monthly x 3, and Quarterly x 4.5.) Audits will be reviewed and monitored during Monthly QA x 3 months then Quarterly x 4 to ensure compliance.	01/14/2012

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	a handwritten note "except Ativan." No self medication administration assessment could be located in the resident's record. On 12/15/11 at 11:31 a.m., LPN #6 indicated she remembered doing a self administration for medications assessment, but could not locate the form. A policy for "Qualifying a Resident for Assisted Living/Pre admission Evaluation", with an annual review date of 11/11/11, was provided by the Director of Health Services on 12/15/11 at 12:38 p.m. The policy indicated: "Purpose: It is the policy of Trilogy Health Services to assess all residents prior to admission to our Assisted Living Residence. Procedure: Each resident shall receive an evaluation which shall be initiated prior to admission and updated at least semiannually and upon a known substantial change in resident's condition or more often at the resident's or facility's request. A licensed nurse shall evaluate the nursing needs of the resident. The preadmission evaluation (interview) shall provide the baseline information for the initial assessment. Subsequent evaluations shall compare the resident's current status to his status on admission and shall be used to assure that the care			

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	the resident requires is within the range of personal care and supervision provided by a residential care facility. The evaluation shall include at least the following...3) resident's ability to self-administer medications, if applicable...."			
R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure service plans were signed and dated by residents for 3 of 5	R0217	1.) DHS and or Designee will review Service Plans for Reisdents # 89, 74 and 106 and	01/14/2012

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NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN47203	

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	residents reviewed for service plans in a sample of 7 (Residents #89, 74, and 106). Findings include: 1. Resident #89's record was reviewed on 12/14/11 at 2:15 p.m. The record indicated Resident #89 was admitted with diagnoses that included, but were not limited to, debility, dizziness, high blood pressure, muscle weakness, sleep disturbance, and diabetes mellitus. An "Evaluation and Service Plan" with a last review date of 8/10/11, 9/1/11, and 11/4/11 were not signed and dated by the resident. During an interview on 12/14/11 at 3:05 p.m., LPN #6 indicated she hasn't been able to get signatures from either of Resident's 89's powers of attorney. 2. Resident #74's record was reviewed on 12/15/11 at 10:48 a.m. The record indicated Resident #74 was admitted on 2/9/11 with diagnoses that included, but were not limited to, Alzheimer's disease, high blood pressure, and agitation. An "Evaluation and Service Plan" with review dates of 2/14/11, 4/8/11, 7/20/11, and 12/12/11 were not signed and dated by the resident.		have Resident or Responsible Party review and sign.2.) DHS and or Designee will audit all Service Plans to ensure that Service Plans are reviewed with Resident or Responsible Party and signed.3.) DHS and or Designee will Inservice A.L. Nursing staff related to reviewing service plans and having the Resident or Responsible Party Sign Service Plan.4.) DHS and or Designee will audit Service Plans monthly x 3, then Quarterly x 4 to ensure deficient practice has been corrected.5.) This will be monitored through the QA meetings montly x 3 then Quarterly x 3.	

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	3. Resident #106's record was reviewed on 12/15/11 at 9:30 a.m. The record indicated Resident #106 was admitted with diagnoses that included, but were not limited to, arthritis, anemia, high blood pressure, low potassium level, and lung problems. An "Evaluation and Service Plan" with review dates of 6/24/11, 7/2/11, and 9/20/11 were not signed and dated by the resident. A policy and procedure for "Service Plan", with an annual review date of 11/11/11 indicated "Procedure: A service plan shall be developed after completion of the evaluation using appropriately trained staff members. This plan shall identify and document services provided by the facility. If administration of medications and/or provision of residential nursing services are needed, licensed nurse shall be involved in identification and documentation of the services to be provided. The service plan shall be reviewed and revised as appropriate. Either the facility or the resident may request a service plan review. Service plan does not need to be updated unless there is a change in the evaluation or a change in the services. The service plan shall be signed and dated			

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	by the resident, and a copy of the service plan shall be given to the resident upon request."			
R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure drug regimen reviews were conducted every 60 days for 1 of 5 residents reviewed for drug regimen reviews in a sample of 7. (Resident #89) Findings include: Resident #89's record was reviewed on 12/14/11 at 2:15 p.m. The record indicated Resident #89 was admitted with diagnoses that included, but were not limited to, debility, dizziness, high blood pressure, muscle weakness, sleep disturbance, and diabetes mellitus.	R0298	1. Resident 89 did have a drug regimen review, Consultant Pharmacist had failed to document in chart. But review was included in Documentation that was given to DHS. 2. ED and DHS audited all A.L. charts to ensure no other residents were affected by citation.3. Inservice by ED with Consultant Pharmacist and Medical Records Director related to Drug Regimen reviews and timeliness.4. Audits to be conducted by DHS or Designee montly x 3 and then Quarterly x 45. Audits to be monitored through QA monthly x3 then Quarterly x 4.	01/14/2012

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	Review of a "Medication Regimen Review" indicated the last drug review was done on 9/13/11. No other drug regimen reviews could be located in the resident's record. During an interview on 12/14/11 at 3:05 p.m., LPN #6 indicated the Pharmacist hasn't been in the facility to check his chart since September. A policy and procedure for "Pharmacy Guidelines" was provided by the Director of Health Services on 12/15/11 at 12:38 p.m. The policy indicated, but was not limited to, "Purpose: To ensure each resident receives the medically necessary medications prescribed by their health care practitioner...5. The campus pharmacy consultant shall review the resident's medication regime every 60 days and make recommendations of their findings to the attending physician."			

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R0356	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to maintain current emergency information on each resident in that 1 resident failed to have an emergency file (Resident #89) and 2 residents failed to have a photograph in their emergency files (Residents #74 and 106). This affected 3 of 5 residents reviewed for emergency information in a sample of 7. Findings include: 1. Resident #89's record was reviewed on 12/14/11 at 2:15 p.m. The record indicated Resident #89 was admitted on 8/30/11 with diagnoses that included, but	R0356	1. Emergency file for Resident #89, 74 and 106 corrected.2. All A.L. emergency files audited by DHS or Designee to ensure no other residents affected by citation.3. A.L. Staff inserviced by DHS or Designee related to emergency binders.4. Audits of emergency binders by DHS or Designee weekly x 3, then monthly x 3 then quarterly x 3.5. This will be monitored monthly in QA x 3 then Quarterly x 3.	01/14/2012

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	were not limited to, debility, dizziness, high blood pressure, muscle weakness, sleep disturbance, and diabetes mellitus. No current emergency information could be located for Resident #89. During an interview on 12/14/11 at 3:25 p.m., LPN #6 indicated Resident #89's emergency file should be here, but it's not, and that it was updated yesterday. 2. Resident #74's record was reviewed on 12/15/11 at 10:48 a.m. The record indicated Resident #74 was admitted on 2/9/11 with diagnoses that included, but were not limited to, Alzheimer's disease, high blood pressure, and agitation. No photograph could be located for Resident #74 in the emergency file. During an interview on 12/15/11 at 12:15 p.m., LPN #6 indicated "It was a good thing you asked about the emergency binder, because it was really outdated." 3. Resident #106's record was reviewed on 12/15/11 at 9:30 a.m. The record indicated Resident #106 was admitted on 5/31/11 with diagnoses that included, but were not limited to, arthritis, anemia, high blood pressure, low potassium level, and lung problems.			

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	No photograph could be located for Resident 74 in the emergency file. During an interview on 12/15/11 at 11:31 a.m., LPN #6 indicated "We are trying to locate a camera to make sure all the residents have pictures for their emergency files." A policy and procedure for "Emergency Information File" was provided by the Director of Health Services on 12/15/11 at 12:38 p.m. The policy indicated: "Procedure: A current emergency information file shall be maintained for each resident. This file shall contain the following: 1) The resident's name, sex, room or apartment number, phone number, age or date of birth 2) The resident's hospital preference 3) The name and phone number of any legally authorized representative 4) The name and phone number of the resident's physician of record 5) The name(s) and telephone number(s) of the family members(s) or other person(s) to be contacted in the event of an emergency or death 6) Information on any known allergies 7) A photograph (for identification of the resident) 8) Copy of advance directives if available."			