

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 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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
--------------------	--	---------------	---	----------------------

R0000	<p>This visit was for the Investigation of Complaint IN00103582.</p> <p>Complaint IN00103582 - Substantiated. State residential deficiencies related to the allegations are cited at R052 and R090.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/16/2011.</p> <p>Survey dates: February 8 and 9, 2012</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Survey team: Diana Sidell RN, TC Cheryl Fielden RN</p> <p>Census bed type: SNF: 48 SNF/NF: 25 Residential: 34 Total: 107</p> <p>Census payor type: Medicare: 28 Medicaid: 19 Other: 60</p>	R0000	<p>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 its letter of credible allegation and requests a desk review of possible , and allegiance compliance on March 10, 2012. Carol Rosemeyer, RN, ED Silver Oaks Health Campus</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: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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>Total: 107</p> <p>Sample: 6 Residential sample: 1</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/15/12 by Suzanne Williams, RN</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203		
(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	
R0052	<p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure residents remained free of abuse in that one incident of misappropriation of a resident's narcotic medication occurred. This affected 1 of 1 resident reviewed for abuse in a sample of 1. (Resident #H)</p> <p>Findings include:</p> <p>Resident #H's record was reviewed on 2/9/12 at 3:00 p.m. The record indicated Resident #H was admitted with diagnoses that included, but were not limited to, dementia with behavioral changes, coronary artery disease, and blood clot in the lung.</p> <p>Physician's orders dated 12/23/11 indicated an order for Roxanol (morphine) 2.5 milligrams (0.125 milliliters) every 4 hours as needed by mouth or under the tongue for mild to medium pain and 5 milligrams (0.25 milliliters) every 4 hours by mouth or under the tongue for severe pain.</p> <p>A controlled drug record was initiated on</p>	R0052	<p>On 12/26/11 Employee left without counting with oncoming shift. Dayshift Nurse counted and noticed that Resident H's Roxanol Count was inaccurate. Dayshift Nurse immediately notified Nurse Manager who called Nightshift nurse to have her come back in for a drug screen. Nurse Manager completed audit of all residents and noted no other residents were affected. Employee called in and quit following Drug Screen and did not return to work. Inservice was completed with nurses related to completing narcotic count when coming on shift and when leaving. Inservice was all completed related to misappropriation of Resident Funds. Nurse Managers to monitor Narcotic Count Sheets weekly to ensure counts are being completed by oncoming and offgoing nurses. Results of Audits to be reviewed monthly in Quality Assurance meeting.</p>	03/10/2012	

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 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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>12/24/11 with a 30 milliliter bottle of Roxanol with a strength of 100 milligrams in 5 milliliters. The initial dose of Roxanol, 0.25 milliliters, had been documented as administered on 12/24/11 at 12:30 a.m. No other doses were documented as given and on 12/26/11, the narcotic count was off by 33 doses of 0.25 milliliters for each dose, for a total of 8.25 milliliters. The controlled drug record had documentation that it was reconciled by LPN #3 and LPN #4 on 12/26/11.</p> <p>A policy titled, "Abuse and Neglect Procedural Guidelines" with an effective date of 11/2011, was provided by the Director of Health Services on 2/8/12 at 11:00 a.m. The policy indicated, but was limited to: "Purpose: Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Prevention...2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...k. Misappropriation of Property - includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...g.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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>Reporting...Immediately and not more than 24 hours complete an initial report to applicable state agencies...."</p> <p>During an interview on 2/9/12 at 3:03 p.m., the DHS indicated the incident was investigated, they did a 100% audit of all residents and no other resident was affected by the narcotic count being "off".</p> <p>A handwritten statement signed by LPN #3 was included with the investigation of this incident, and indicated: "I was...manager on 12/26/11. It was brought to my attention [LPN #2] had not counted narcotics at end of her shift with oncoming nurse. Upon investigation and counting of narcotics [LPN #4] noted morphine to be off count. I then went to unit to confirm discrepancy in count. [LPN #2] at that time was no longer at facility. I called her to come for drug testing, also informed [LPN #4] she would need to go to drug testing due to count discrepancy. Took both nurses to [name of facility] for drug testing and corrected count on narc (narcotic) log [with] witness present."</p> <p>The Executive Director indicated on 2/9/12 at 3:15 p.m., the Roxanol had been replaced by the facility.</p> <p>This Residential tag relates to Complaint</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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
	IN00103582.			

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 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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
--------------------	--	---------------	---	----------------------

R0090	<p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a</p>			
-------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203			
(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>notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to report one incident of misappropriation of a resident's narcotic medication to the Indiana State Department of Health (ISDH) within 24 hours. This affected of 1 of 1 resident reviewed for unusual occurrences in a sample of 1. (Resident H)</p> <p>Findings include:</p> <p>A Fax/Incident Report, dated as faxed to the Indiana State Department of Health (ISDH) on 1/10/12, was provided by the Director of Health Services (DHS) on 2/9/12 at 2:20 p.m. The fax/incident report indicated "Brief Description of Incident: On 12/26/2011 Employee left without counting with oncoming shift. Dayshift Nurse counted and realized Resident's Morphine count was off. Nurse Manager immediately notified and Nurse was called to return to facility and taking her to (name of facility) for drug screen. Type of Injury/Injuries: None. Immediate Action Taken: Employee called in and quit following drug screen. Random Drug Screen performed.</p>	R0090	<p>On 12/26/12 Employee left without counting with oncoming shift. Dayshift Nurse counted and realized Resident's Roxanol count was off. Nurse Manager immediately notified and Nurse was called to return to facility and taking her to prompt med for drug screen. Employee called in and quit following drug screen and did not return to facility. Incident was not reported until drug screen result obtained which tested positive for morphine. Executive director and or Desginee will review all incidents to ensure timely reporting. Audits completed on all incidents since previous survey, no further Resident's were effected by citation. Inservice completed with staff related to Misappropriation of funds. Quality Assurance team will monitor incidents and accidents monthly to ensure timely reporting of unusual occurrences.</p>	03/10/2012			

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 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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>Preventative Measures Taken: Inservice completed with nurses related to completing narcotic count when coming on shift and when leaving shift. Follow-up Nurse quit following Drug Screen which tested positive for Morphine."</p> <p>A handwritten statement signed by LPN #3 was included with the investigation of this incident, and indicated: "I was...manager on 12/26/11. It was brought to my attention [LPN #2] had not counted narcotics at end of her shift with oncoming nurse. Upon investigation and counting of narcotics [LPN #4] noted morphine to be off count. I then went to unit to confirm discrepancy in count. [LPN #2] at that time was no longer at facility. I called her to come for drug testing, also informed [LPN #4] she would need to go to drug testing due to count discrepancy. Took both nurses to [name of facility] for drug testing and corrected count on narc (narcotic) log [with] witness present."</p> <p>A policy titled, "Abuse and Neglect Procedural Guidelines" with an effective date of 11/2011, was provided by the Director of Health Services on 2/8/12 at 11:00 a.m. The policy indicated, but was limited to: "Purpose: Trilogy Health Services, LLC (THS), has developed and</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
---	--

(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>implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Prevention...2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...k. Misappropriation of Property - includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...g. Reporting...Immediately and not more than 24 hours complete an initial report to applicable state agencies...."</p> <p>During an interview on 2/9/12 at 3:03 p.m., the DHS indicated the incident was investigated but not reported right away to the ISDH, they did a 100% audit of all residents and no other resident was affected by the narcotic count being "off".</p> <p>This Residential tag relates to Complaint IN00103582.</p>			
--	---	--	--	--