

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
--	--

(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 a Recertification and State Licensure Survey.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00117339.</p> <p>Survey dates: October 9-12, 15-18, 2012</p> <p>Facility number: 000513 Provider number: 155426 AIM number: 100275360</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN 10/9-11, 16-18, 2012 Teresa Buske, RN Debra Skinner, RN 10/9-11, 15-18, 2012</p> <p>Census bed type: SNF/NF: 164 Total: 164</p> <p>Census payor type: Medicare: 20 Medicaid: 120 Other: 24 Total: 164</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	Royal Oaks is requesting a desk review of the plan of correction rather than an on site revisit. Thank You, Susan Baker, RN, DNS	
-------	---	-------	--	--

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: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
	IAC 16.2. Quality review 10/23/12 by Suzanne Williams, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F0223 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 observation, interview and record review, the facility failed to ensure all residents were free from verbal abuse for 1 of 4 allegations of abuse reviewed (Resident #11).</p> <p>Findings include:</p> <p>1. On 10/9/12 at 11:15 a.m., Resident #11 was observed to be up in wheelchair and required total care.</p> <p>Upon review of an investigation, provided by the facility on 10/17/12 at 12:45 p.m., documentation indicated Resident #11 was verbally abused by CNA #15. The documentation indicated on 10/16/12 at approximately 11:07 a.m., Student Nursing Assistant [SNA] #13 observed CNA #15 to verbally tell Resident #11 that "she had better be glad she was at work or otherwise she would beat the [s--t] out of her." The documentation also indicated that SNA #13 remained with the</p>	F0223	<p>The employee that verbally abused resident #11 was immediately suspended. Social Services provided follow-up with the resident to ensure there were no signs of psychosocial harm for a period of at least 72-hrs. There was no evidence of harm identified. The C.N.A. was terminated from employment. All Residents that were assigned to the C.N.A. were identified as having the potential to be affected by the same deficient practice. Social Services interviewed those residents that were interviewable. There were no negative findings. Licensed Unit Managers of those assignments completed a body assessment for those that were not interviewable. There were no negative findings. Royal Oaks continues to require background checks and reference checks for all new hires. Royal Oaks does not employ known abusers. The Abuse policy is reviewed during each new hire orientation as well as routinely following our annual inservice calendar. Reports of abuse are immediately reported</p>	11/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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 to assist CNA #15 to complete care for the resident, and at approximately 11:12 a.m., SNA #13 reported the incident to LPN, Unit Manager, #14. Documentation indicated CNA #15 was suspended at 11:21 a.m.</p> <p>During interview of SNA #13 on 10/17/12 at 10:35 a.m., the SNA indicated she was familiar with Resident #11. The SNA stated the resident resisted care during the shower and that she observed Resident #11 to pinch, kick and bite CNA #15 while being showered. The SNA indicated that CNA #15 stated to the resident while drying her off "you are lucky I'm at work or I would kick your [a--]." SNA indicated the resident did not respond to CNA #15 and didn't appear upset.</p> <p>Upon review of the clinical record of Resident #11 on 10/16/12 at 12 p.m., the most recent Minimum Data Set (MDS) assessment was noted dated 9/7/12. The assessment identified the resident with moderate impairment in cognitive decision making skills; verbal behavioral symptoms directed toward others that occurred 4 to 6 days but not daily; and total dependence for bed mobility, transfers, locomotion, dressing,</p>		<p>to the Executive Director. Reports of abuse are reported to the Performance Improvement Committee monthly to ensure policies and procedures are followed related to hiring practices, reporting abuse and ongoing inservicing. Date of compliance 11-17-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>eating, personal hygiene and bathing. The resident's diagnoses included, but were not limited to, depressive psychosis, vascular dementia, anxiety state, depressive disorder, altered mental status, and late effect cerebrovascular aphasia.</p> <p>During interview of the Director of Nursing Services [DNS] on 10/18/12 at 12:12 p.m., the DNS indicated the facility substantiated verbal abuse by CNA #15 to Resident #11, and the CNA was terminated from employment.</p> <p>3.1-27(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F0242 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 interview and record review, the facility failed to honor residents' choices for time of rising in the mornings and/or toileting preferences for 3 of 3 residents reviewed of 5 who met the criteria for choices. [Residents # 214, #106, and # 253]</p> <p>Findings include:</p> <p>1. Resident #214 was interviewed on 10/10/12 at 10:46 a.m. The resident indicated she is gotten up in the mornings at 5:00 a.m. and doesn't go to breakfast until 7:20 a.m. The resident indicated she does not like to get up that early.</p> <p>CNA #2 was interviewed on 10/16/12 at 9:48 a.m. The CNA indicated he comes on duty at 6:00 a.m. and the resident is usually dressed and up. The CNA indicated the resident requires assistance to get up and get dressed.</p>	F0242	<p>Residents #214, #106 and #253 are not able to be identified by the facility, however, unit managers have conducted interviews of residents residing on each of their assigned units which would include #214, #106 and # 253. Interviews were conducted to ensure their choices for time of rising and toileting preferences are honored. Their choices will be documented on the individual care plans and the C.N.A. assignment sheets. All residents residing in the nursing center have been identified as having the potential to be affected by the same deficient practice. Interviews have been conducted by the Unit Managers assigned to the residents to ensure their choices for time of rising and toileting preferences are honored. For those residents that are unable to voice their choices due to a cognitive deficit, the resident's responsible party will be interviewed to assist the I.D.T. in care planning for those residents to honor their choices. Their choices will be documented</p>	11/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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 #214's clinical record was reviewed on 10/12/12 at 10:00 a.m. A Minimum Data Set [MDS] assessment, dated 9/26/12, coded the resident with no cognitive impairment required limited assistance of one for bed mobility and transfers and extensive assistance of one for ambulation, dressing and hygiene. An MDS dated 4/20/12, indicated it was very important for the resident to choose own bed times.</p> <p>A plan of care with most recent update of 5/15/12, addressed alteration in self care related to cognitive decline, dementia, impaired mobility, general weakness, congestive heart failure and anemia.</p> <p>2. Resident #106 was interviewed on 10/11/12 at 3:47 a.m. The resident indicated she is woken up at 5:00 a.m. so she can be changed. The resident indicated she uses a bedpan at night but would rather go to the bathroom. The resident indicated they bring a bed pan at night, and they say they don't get residents up to the bathroom at night.</p> <p>On 10/15/12 at 1:40 p.m. CNA #16 was interviewed. The CNA indicated she works days, but for the most part</p>		<p>on the individual care plans and the C.N.A. assignment sheets. Inservice training will be provided for current licensed staff nurses as well as newly hired licensed nurses. The training will address the expectation that the licensed nurse will interview the resident and/or the resident's responsible party to identify his/her choice for time for rising and toileting preferences. The residents choice will be documented on the resident's individual care plan and C.N.A. assignment sheets. The Unit Manager will validate that the residents choices were identified and documented on the care plan and the C.N.A. assignment sheet. The validation/monitoring will occur the first business day following admission by the Unit Manager, monthly by the Resident Council Members and then finally by the MDS team at least quarterly during care plan conferences. The Unit Manager will write each new admission's name on the white board in the conference room used by the IDT for verification by the IDT that resident choices for time of rising and toileting preferences are being honored. The DNS will report findings to the Performance Improvement Committee monthly until the Committee determines the facility has been in compliance for at least six consecutive months to ensure the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>thinks the resident utilized the bedpan at night. The CNA indicated when the resident first was admitted to the facility, she required total assistance of two for transfers, and later in her stay required assistance of one.</p> <p>CNA #2 was interviewed on 10/16/12, 9:28 a.m. The CNA indicated he was not sure if the resident utilized a bedpan at night, but night shift would report the resident was toileted, changed or used a bedpan.</p> <p>A Minimum Data Set [MDS] assessment dated 8/29/12, indicated the resident required extensive assistance of one for toileting, was always continent of bowel and bladder. The assessment indicated it was very important for the resident to choose bed times and clothing.</p> <p>An initial care plan dated 8/22/12 for toileting indicated the resident had bathroom privileges and utilized a bedpan. The care plan indicated the resident required two persons for assistance.</p> <p>A form titled Late Loss ADL [activities of daily living] flow sheet for August 12, documented toilet use, how resident uses the toilet room/commode/bedpan/urinal,</p>		process is in place.Date of compliance 11-17-12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>transfers on/off toilet, cleanses self, changes pad, manages ostomy or catheter, and adjusts clothes.</p> <p>Documentation on the flow sheet for August 25-31 was noted on day shift of the resident being totally dependent on staff assistance of two, and for the night shift for August 25-29, documentation was noted of the resident requiring limited assistance of one.</p> <p>During the interview of CNA #2 on 10/16/12 at 9:48 a.m., the CNA indicated one CNA works the resident's unit on night shift and another CNA splits time between Resident #106's unit and another unit.</p> <p>3. During interview of Resident #253 on 10/11/12 at 12:38 p.m., the resident indicated the night shift staff "wakes us up around 3 am to get dressed." The resident indicated "sometimes I go back to bed. I don't go to breakfast till a little after 7 a.m., and then to therapy around 9 a.m. I don't want to get up that early; I just thought that was the rule."</p> <p>During interview of CNA # 2 on 10/17/12 at 11:05 a.m., the CNA indicated Resident # 253 "is dressed when I come in at 6 a.m." The CNA indicated the resident has indicated she does not want to be woke up that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>early. The CNA indicated he had not told anyone about Resident #253's concern.</p> <p>Resident #253's clinical record was reviewed on 10/17/12 at 12 noon. An admission MDS (minimum data set) assessment was noted, dated 9/28/12.</p> <p>The MDS indicated the resident required assistance of one person for bed mobility and transfers and had a BIMS (Brief Interview for Mental Status) of 7. The assessment indicated choosing your own bedtime was very important to the resident.</p> <p>3.1-3(u)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
--	--

(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
F0282 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 follow a plan of care for nutrition, for 1 of 3 residents reviewed of 6 who met the criteria for nutrition. [Resident #204]</p> <p>Finding includes:</p> <p>On 10/16/12 at 11:59 a.m. Resident #204 was observed with a lunch tray in her room. The resident was observed to have been served beef stew, cornbread, brownie, slaw, iced tea, and water. The resident indicated she was not going to eat. The resident indicated she had soup the day before and liked that. The dietary card provided with the resident's meal, identified by the Registered Dietitian [RD] during an interview on 10/17/12 at 9:30 a.m. as what is utilized by the dietary department to prepare residents' meals, was observed with documentation of Heart Healthy, regular, standard size portions diet. Beverages for lunch: 4 ounces juice, 8 ounces coffee, 8 ounces of 2</p>	F0282	<p>Resident #204 no longer resides in the nursing center. The dietary card was corrected prior to the residents planned discharge home. All residents that have had recommendations from the Registered Dietician have been identified as having the potential to be affected by the same deficient practice. The RD met with the Manager of Nutrition Services. Together they reviewed all current resident's dietary cards to ensure the dietary cards reflect the RDs current recommendations. New measures put into place are as follows: At the time the RD makes a recommendation she will 1) document her recommendation in the resident's progress notes 2) communicate her recommendation to the dietary department by documenting the recommendation on a communication tool 3) she will make copies of the communication tool for her records, for the Unit Manager and for the resident's MDSC. 4) the RD will personally deliver the recommendation on the communication tool to the dietary department 5) the RD will then write the recommendation on the</p>	11/17/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>percent milk.</p> <p>At 12:10 p.m. a CNA was observed to enter the resident's room, asked the resident if she was going to eat or would like something else, and the resident indicated no. The CNA exited the room and returned to the dining room.</p> <p>A form titled "Resident Weight History" reviewed on 10/17/12 at 9:43 a.m., included documentation of weight on 9/6/12, 119 pounds. On 10/1/12, weight 108.8 pounds, and "po [by mouth] intake remains poor. Family provides Boost. Drinks one bottle four times daily. Does not like Ensure. Daughter visits frequently. Receives Lasix [diuretic] 40 mg daily. Nursing reports no edema. Continue to encourage and provide calorie dense foods." Documentation dated 10/8/12 was noted of "eats 50 percent or less. ...Will provide calorie dense meals."</p> <p>A physician's order was noted for regular diet. Diagnoses included, but were not limited to, congestive heart failure.</p> <p>A plan of care was noted for inadequate/suboptimal oral food/beverage intake. Approaches included, but were not limited to,</p>		<p>white board in the conference room used by the IDT for verification by the IDT that the recommendation was written on the resident's dietary card prior to the next meal service 6) the RD will update the resident's nutrition care plan interventions to include the new recommendationsThe RD will report findings monthly to the Performance Improvement Committee monthly until the Committee determines the facility has been in compliance for at least six consecutive months to ensure the process is in place. Date of compliance 11-17-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>medical food supplements four times daily, allow sufficient time to eat, encourage family/significant others to visit at meal times and bring in favorite foods. An approach was noted dated 9/19/12 to start calorie dense foods each meal.</p> <p>On 10/17/12 at 9:30 a.m. the RD was interviewed. The dietician provided documentation of a dietary recommendation dated 9/18/12 for the resident to receive whole milk, all meals, extra margarine, juice, ice cream with breakfast and lunch. The dietician indicated the recommendations should have been on the resident's dietary cards for servers to know what to provide to the resident and indicated the information was not on the card. The dietician indicated a physician's order was not required for the recommendation.</p> <p>3.1-35(g)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
F0315 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 and record review, the facility failed to ensure a resident with a Foley catheter received services to prevent UTIs (urinary tract infections) for 1 of 1 resident reviewed with a Foley catheter, in that during cleansing of incontinent bowel movement, the urinary drainage bag was place on the bed, and gloves were not changed appropriately. (Resident #153)</p> <p>Findings include:</p> <p>On 10/16/12 at 11:10 am , CNAs # 3 and #4 provided incontinence care to Resident #153. Resident #153 was lying in bed and had a large BM [bowel movement]. During cleansing CNA #3 placed the resident's urinary drainage bag, with urine in the bag on the resident's bed, not below the level</p>	F0315	Resident #153 is provided care that includes ensuring the urinary drainage bag remains below the level of the bladder at all times and that staff members follow polices and procedures related to changing soiled gloves at appropriate times during incontinence care. Other residents that have the potential to be affected by the same deficient practice have been identified as those that have an indwelling urinary catheter and those who are provided with incontinence care. The Staff Developemt Coordinator (SDC) and Infection Control Nurse (ICN) are providing inservice education reviewing the policy and procedures for Foley catheter handling and Incontinence Care with special emphasis on the importance of keeping the urinary drainage bag below the level of the bladder at all times and the practice of changing gloves after cleansing feces from the resident before	11/17/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>of the resident's bladder. The drainage bag remained on the bed during the cleansing of the resident. During the cleansing of the resident, CNA #4 wore the same gloves used to cleanse feces from the resident, to provide pericare and Foley catheter care.</p> <p>During review of the facility policy titled "Indwelling Urinary Catheter Care", dated 8/31/12 and received on 10/17/12 at 10:30 am from the DNS (Director of Nursing Services), documentation indicated "If resident has had an involuntary bowel movement, clean this area first to eliminate contamination. Change gloves to prevent contamination of catheter and meatal junction." and "Position the collecting-bag below the level of the bladder at all times. Do not rest the bag on the floor."</p> <p>3.1-41(a)(2)</p>		<p>providing pericare and Foley catheter care. Current nurses and C.N.A.s will receive the inservice. The S.D.C. will ensure newly hired nursing staff receive the same education upon hire before providing care to the residents. The ICN will conduct random observations of resident care related to Foley catheter handling and bowel incontinence care. She will conduct the random observations on all 3 shifts observing at least 20 residents receiving care each month. Identified deficiencies will be corrected at the time of identification with documentation of the employee violating policy & procedures. Employees identified as being deficient will be observed again at an unexpected time to ensure reeducation was successful. Further deficiencies identified by the same employee will result in progressive disciplinary action. The ICN will report findings to the Performance Improvement Committee monthly until the Committee determines the facility has been in compliance for at least six consecutive months to ensure the process is in place. Date of compliance 11-17-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F0323 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 the residents' environment was free of accident hazards for 1 resident (#40) with a loose toilet and 1 of 2 (#153) residents observed transferred with a mechanical lift in that staff failed to follow manufacturer's recommendations concerning use of a mechanical lift.</p> <p>Findings include:</p> <p>1. On 10/10/12 at 11:50 a.m., Resident #40's bathroom was observed with the toilet loose at the base and was partially turned sideways. CNA #8 easily moved the toilet forward and back on the waxed ring.</p> <p>During interview on 10/10/12 at 11:50 a.m., CNA #8 indicated she noticed the toilet last week to be loose. The CNA indicated the toilet was loose from wheeling the resident's wheelchair into the bathroom, to transfer the resident to the toilet, and</p>	F0323	<p>Resident #40s toilet has been replaced with a new toilet that is secure and does not move. Resident #153 is being safely lifted with a Hoyer mechanical lift by unlocking the wheels on the lift while lifting and lowering the resident. Other residents having the potential to be affected by the same deficient practices have been identified as: 1) anyone using a toilet for elimination 2) anyone requiring the use of a mechanical lift for transfers. The Staff Development Coordinator (SDC) is providing inservice education reviewing: 1) the expectation that maintenance is to be notified immediately, both verbally & also on the maintenance communication log, when a loose toilet is identified 2) manufacturers guidelines for the use of mechanical lifts with special emphasis on when the brakes are to be engaged and disengaged. Current nurses and C.N.A.s will receive the inservice. The SDC will ensure newly hired nursing staff receive the same education upon hire before providing care to the residents. 1) The SDC will point out the location of the</p>	11/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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 wheelchair hitting the toilet. The CNA indicated she was not aware of anyone reporting the loose toilet to the maintenance person.</p> <p>During interview of the maintenance person on 10/17/12 at 10:20 a.m., the maintenance person, concerning procedure for reporting issues in resident's room, indicated "I have a log at every nursing station. I have to replace toilets routinely; they get knocked with wheelchairs and the base becomes loose. I had a man fix the resident's toilet, but he didn't do it right. When they told me about [Resident #40's] toilet, I went down and put in a new toilet."</p> <p>Resident #40's clinical record was reviewed on 10/17/12 at 3 p.m. A quarterly assessment, dated August 2012, indicated the resident required assist of two persons during transfers.</p> <p>2. During observation of care on 10/16/12 At 11:10 a.m. CNAs # 3 & 4 transferred Resident #153 from the bed to a wheelchair utilizing a Hoyer mechanical lift. CNA #3 locked the wheels on the lift, while lifting the resident from the bed, and when lowering the resident to the wheelchair.</p>		<p>maintenance log on each unit during the tour of newly hired employees. 2) CNAs will complete a mechanical lift competency with their annual evaluations by the SDC.1) The maintenance department will ensure toilets are secured with each resident discharge from the facility. The maintenance department will check each maintenance log at least daily. The maintenance department will report to the Executive Director identification of loose toilets that were known by nursing staff members but had not been verbally reported and documented in the maintenance log for corrective action. 2) The Unit Managers and Charge Nurses will conduct and document @ least 1 random mechanical lift observation on their shift to ensure brakes are locked and unlocked at appropriate times per manufacturers guidelines. Negative findings will be corrected at the time of observation with documentation of the deficiency utilizing a Performance Improvement Form. The PI form will be forwarded to the SDC. The SDC will have the CNAs complete a mechanical lift competency in the class room. Further deficiencies by the same CNA will result in further disciplinary action up to and including termination of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>An undated facility procedure, titled "Hoyer-General Use Instructions," received on 10/17/12 at 1:52 p.m. from the DNS (Director of Nursing Service), indicated "...Remember, when lifting patient, the parking brake should not be used."</p> <p>A quarterly assessment, dated 8/16/12, indicated the resident was dependant for transfers.</p> <p>3.1-45(a)(1)</p>		<p>employment. The Maintenance Supervisor and the SDC will report their monthly findings to the Performance Improvement Committee for at least three consecutive months to ensure compliance. Date of compliance 11-17-12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure the environment and equipment remained sanitary, clean and without debris, for 1 of 1 kitchen area and 4 of 9 nursing areas [200 hall, 600 hall, 700 hall, and 800 hall]. This had the potential to affect 164 of 164 residents of the facility.</p> <p>Findings include:</p> <p>1. On 10/9/12 at 10:25 a.m. during initial kitchen observation, the following was observed:</p> <p>a. The flour and sugar container covers were observed to be soiled with accumulation of dust and splatters.</p> <p>b. The walk-in refrigerator floor was observed with dirt and debris. The debris was noted to be under the shelving units and in the center floor area.</p> <p>During interview of kitchen staff person #30 on 10/9/12 at 10:35 a.m., the staff person indicated the floor had been swept approximately 2 days</p>	F0465	<p>1) a. The flour and sugar container covers have been cleaned and are free from dust and splatters b. The walk-in refrigerator floor has been swept and cleaned daily. 2) The medication carts on 200 hall, 600 hall and 800 hall have been cleaned. 3) The holes in the walls in rooms 601 and 801 have been repaired. 4) The dark and rust colored substances on the top and sides of the 800 hall medication cart have been repaired 5) The 600 hall nursing station floor covering and room 714 flooring has been replaced by maintenance. 6) The bathroom door in room 801 has been repaired. 7) The touch pad call light in room 801A has been cleaned. 8) The broken slats on the wall air conditioner/heating unit in room 709 has been replaced. 9) The urine odor on 700 hall has been resolved. The 700 hall Unit Manager, Housekeeping Supervisor and Maintenance Supervisor made rounds on the entire unit to ensure: residents are clean and dry, w/c cushions & mattresses are clean, waste paper baskets are emptied, toilets are flushed and cleaned, urinals and bedpans are</p>	11/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>ago.</p> <p>Upon review of the cleaning schedule dated 10/2012, provided on 10/10/12 at 9:36 a.m., the documentation indicated the cooler floor had been swept and/or mopped daily 10/4-10/9/12.</p> <p>2. The medication cart on the 200 hall was observed to have heavy accumulation of splatters and spillage down the sides and at the base of the cart on 10/16/12 at 11 a.m.</p>		<p>clean, f/c drainage bags & dignity bags are clean & free of odors,surfaces, floors, drapes, privacy curtains are clean, bedding, personal items, clothing and shoes are clean,soiled linen barrels are clean,shower rooms and drains are clean.All residents residing in the nursing center have the potential to be affected by the same deficient practices.</p> <p>1) a.& b.The Executive Director (ED) has reviewed the kitchen cleaning schedule with the Nutrition Service Manager (NSM). The NSM has inserviced dietary employees to ensure there is a clear understanding of who is to do what and when. The cleaning schedule is posted with a well defined schedule for cleaning. 2) The Staff Development Coordinator (SDC) has inserviced the licensed nurses regarding the expectation that the medication cart is to be inspected and cleaned by the charge nurse at the beginning of the shift and at the end of the shift. 3) The ED has inserviced the Maintenance Supervisor(MS) regarding the expectation that rooms are to inspected as a resident is discharged to ensure there are no holes in the walls. The ED has inserviced the Housekeeping Supervisor (HS) regarding the expectation that housekeeping employees are to report holes in walls to the maintenance department via the maintenance log kept at each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
--	--

(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
			nurses station. The SDC has inserviced all departments that it is the responsibility of each employee to report holes in walls to the maintenance department via the maintenance log kept at each nurses station. 4) The DNS has inserviced the UM that they are to inspect the medication carts at least weekly to ensure they are clean and free from rust spots. Rust spots are to be reported to the maintenance department via the maintenance log kept @ each nurse's station.5) The ED has inserviced the HS the expectation that housekeeping employees are to report worn or missing flooring to the maintenance department via the maintenance log kept @ each nurse's station. The SDC has inserviced all departments that worn or missing flooring is to be reported to the maintenance department via the maintenance log kept @ each nurse's station.6) The ED has inserviced the HS regarding the expectation that housekeeping employees are to report holes in doors in the resident rooms to the maintenance department via the maintenance log kept @ each nurse's station. The SDC has inserviced all departments that it is the responsibility of each employee to report holes in doors to the maintenance department via the maintenance log kept at each nurse's station.7) The SDC has inserviced the nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
--	--

(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>regarding the expectation that call bells are to be inspected for cleanliness each time the call light is offered to the resident and or place on the resident's bed after making the bed. If the call bell is noted to be soiled it is to be cleaned at that time.8) The ED has inserviced the HS the expectation that housekeeping employees are to report broken slats on the wall air conditioning/heating units to the maintenance department via the maintenance log kept @ each nurse's station. The SDC has inserviced all departments regarding the expectation that it is the responsibility of each employee to report broken slats on the wall air conditioning/heating units to the maintenance department via the maintenance log kept at each nurse's station. 9) The SDC has inserviced the nursing staff the expectation that toilets are to be flushed immediately after emptying bedpans into the toilets. The SDC has inserviced all departments that it is each employees responsibility to report noted urine odors immedieatly to the charge nurse on duty. If the urine odor can not be identified and corrected immediately the charge nurse is to notify the ED & DNS for investigation by Nursing, Housekeeping and Maintenance to find the source and correct the urine odor.The corrective actions</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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. On 10/16/12 at 11:32 a.m. Resident room 601 was observed with a large hole in the wall behind a chair in the resident's room.</p> <p>4. On 10/16/12 at 11:30 a.m. the 600 hall medication cart was observed with dried-on spatter on the end of the medication cart where the trash disposal and sharps container were located.</p> <p>5. On 10/16/12 at 11:45 a.m. the 800</p>		<p>will be monitored for effectiveness utilizing rounding tools. The rounding tools will be completed by:1) ED - weekly2) Infection Control Nurse (ICN) - weekly3) ED - monthly4) ICN - weekly5) ED - monthly6) ED - monthly7) ICN - weekly8) ED - monthly9) ICN - daily investigaton of lingering urine odorsThe above listed monitoring tools will be summarized by the Executive Director (ED) with identified opportunities for improvement and/or trends to be reported to the Performance Improvement Committee. The ED will report findings to the Performance Improvement Committee monthly until the Committee determines the facility has been in compliance for at least six consecutive months to ensure the process in is place.Date of compliance 11-17-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
--	--

(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>hall medication cart was observed with dried-on dark and rust colored substances on the top and sides of the cart. The exterior of the sharps container on the side of the cart was observed with dried-on substances.</p> <p>6. On 10/18/12 at 2:00 p.m. the 600 hall nursing station was observed with an area of floor covering approximately 2 feet by one and a half feet worn away.</p> <p>7. On 10/16/12 at 11:46 a.m. Room 801 was observed with a hole in the wall approximately 12 inches by four inches. A hole was observed in the hollow core bathroom door approximately three inches by one-half inch. The touch pad call light in position for the resident in bed A of the room was observed with soiled surfaces.</p> <p>8. On 10/09/12 at 1:05 PM, a heavy urine odor was noticed at the front of the 700 hall.</p> <p>9. On 10/10/12 at 9:30 am, a heavy urine odor was noted at the end of the 700 unit.</p> <p>10. On 10/10/12 at 12 noon, room # 714 had an area of flooring, to the left of the entry door, missing. The bathroom had a heavy urine odor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>11. On 10/10/12 at 11:50 am, the wall air conditioner/heating unit in room 709 had several broken slats.</p> <p>12. On 10/11/12 at 10 a.m., the door to the bathroom in room 709 was open. A urine odor was noted. The toilet was noted with urine and toilet paper in the toilet.</p> <p>13. During interview of Resident #170 on 10/11/12 at 10 a.m., the resident indicated the staff had emptied her bedpan in the toilet. No staff were observed in the room.</p> <p>14. On 10/11/12 at 2:30 PM, a strong urine odor was noted the full length of the 700 hall.</p> <p>3.1-19(f)</p>				