

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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 |
|--------------------|--|---------------|--|----------------------|
| F000000            | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00121870.</p> <p>Complaint IN00121870 - Substantiated. Federal/state deficiencies related to the allegations are cited at F281.</p> <p>Survey dates: February 25, 26, 27, 28, March 1, and 4, 2013</p> <p>Facility number: 002955<br/>Provider number: 155693<br/>AIM number: 200346570</p> <p>Survey team:<br/>Diana Sidell RN, TC<br/>Debra Peyton RN<br/>Gordon Tyree RN<br/>Gwendolyn Phumphrey RN<br/>Barbara Gray RN (March 2, 2013)<br/>Angel Tomlinson RN (March 2, 2013)</p> <p>Census bed type:<br/>SNF: 47<br/>SNF/NF: 26<br/>Residential: 35<br/>Total: 108</p> <p>Census payor type:</p> | F000000       | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure and Complaint Survey (IN00121870) Survey on March 4, 2013. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>Medicare: 22<br/>Medicaid: 18<br/>Other: 68<br/>Total: 108</p> <p>Residential sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 6, 2013 by Cheryl Fielden RN</p> |   |   |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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 |
|--------------------|--|---------------|---|----------------------|
| F000281<br>SS=D    | <p>483.20(k)(3)(i)<br/>SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br/>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on record review and interview, the facility failed to ensure a physician's order for a foley catheter included the catheter size and amount of fluid to inflate the catheter bulb. This affected 1 of 3 residents reviewed for professional standards of quality related to foley catheter use. (Resident #A)</p> <p>Findings included:</p> <p>Resident #A's record was reviewed on 2/28/13 at 4:10 p.m. The record indicated Resident #A had diagnoses that included, but were not limited to, debility, insulin dependent diabetes mellitus, atrial fibrillation, metabolic encephalopathy (brain dysfunction/disease), dementia, and hyperlipidemia.</p> <p>A physician's order dated 8/11/12 indicated an initial order for: "Change foley cath[eter] PRN (as needed) for occlusion or dislodgement." The order as written did not include the catheter size nor the amount of fluid</p> | F000281       | <p><b>F 281</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #A has been discharged.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review the medical record of all residents with a catheter in place to ensure a physician's order for the catheter includes the catheter size and amount of fluid to inflate the catheter bulb.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Insertion of a Foley Catheter</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does</b></p> | 04/03/2013           |

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>to inflate the bulb.</p> <p>August, 2012, Treatment Administration Records (TARS) indicated the foley catheter had been anchored on 8/11/12 and changed on 8/23/12.</p> <p>A physician's telephone order, dated 9/13/12, indicated "DX (diagnosis) for Foley catheter, 16FR (french) 10CC (bulb to be filled with 10 cubic centimeters of fluid) for neurogenic bladder (difficulty draining urine from the bladder)."</p> <p>Physician recapitulation orders dated 12/01/12 through 12/31/12 indicated an order to "change F/C (foley catheter) as needed for occlusion or dislodgement", and the order as written did not include the catheter size nor the amount of fluid to inflate the bulb.</p> <p>Nurse's "Follow up" notes, dated 10/12/12, on the 10 p.m., to 6 a.m. shift indicated: "F/C (foley catheter) dislodged during BM. Balloon still inflated [with] 6 CC. Reanchored 16 Fr F/C, 7 CC d/t dislodgement F/C patent and draining yellow clear urine."</p> <p>During an interview on 3/4/13 at 3:41</p> |   | <p><b>not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of the medical record of all residents with a catheter in place to ensure a physician's order for the catheter includes the catheter size and amount of fluid to inflate the catheter bulb.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>p.m., the ADON indicated she did not see on the recapitulation orders that the order for the Foley catheter and bulb size was carried over.</p> <p>A policy and procedure for "Guidelines for Insertion of a Foley Catheter", with a last review date of 11/9/12, was provided by the Administrator on 3/4/13 at 3:50 p.m. The policy included, but was not limited to, "Purpose: To provide for and maintain constant urinary drainage, to monitor the kidney functions of the seriously ill resident, and to obtain a urine specimen for diagnostic purposes. Procedure: 1. The following equipment and supplies may [be] necessary when performing this procedure. a. Foley catheter tray (size specified by the ordering physician)...6. The following information should be recorded in the resident's medical record: a. the date and time the procedure was performed...d. the size of the Foley catheter inserted and the amount of fluid used to inflate the bulb...."</p> <p>This Federal tag relates to Complaint IN00121870.</p> <p>3.1-35(g)(1)</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

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

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          |  |                     |  |                            |

|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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   |  |   |  |
| F000371<br>SS=E   | <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions in that food items were not labeled properly, hair was not completely covered with hairnets, and a nourishment refrigerator had a red substance throughout the interior. This deficient practice had the potential to effect 73 of 73 residents currently residing in the facility.</p> <p>Findings Include:</p> <p>During initial tour of the kitchen on 2/25/13 at 10:00 a.m., three bottles of opened salad dressing, one package of opened dry macaroni, and one gallon of opened milk was not dated. The Dietary Manager (DM) was observed dating the three bottles of salad dressing, and package of dry macaroni. The DM instructed kitchen staff #1 to date the opened gallon of milk. When interviewed during the</p> | F000371   | <p><b>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Audit of all opened food to ensure the food is labeled properly. 2). Audit of the dry storage area to ensure only items belonging in this area are being stored here. 3). Observation of employees in the kitchen area to ensure hair nets are completely covering their hair. 4). The nourishment refrigerator on the 600 hall will be cleaned 5). Remove all food items / containers / liquids from nourishment refrigerator on the 600 hall that are not properly dated <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Dietary Manager or designee will re-educate the Dietary Team on</p> | 04/03/2013   |  |   |  |

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>initial tour, the Dietary Manager indicated it was the responsibility of the DM to ensure food was labeled properly. The DM indicated the dates were known because the DM opened the items and observed kitchen staff #1 open the gallon of milk.</p> <p>During the initial tour of the kitchen, on 2/25/13 at 10:00 a.m., in the dry storage area, several containers of vinegar and flavored syrup was found on shelves with dry storage. When interviewed the DM indicated these items did not belong with the dry storage and was supposed to be thrown away. Observed the DM then take the items and discard them.</p> <p>During the lunch meal preparation, on 2/25/13 at 11:35 a.m., observed kitchen staff #1 and kitchen staff #2 with hair nets not completely covering their hair.</p> <p>On 3/4/13, at 10:00 a.m., observed the nourishment refrigerator, located on the 600 hall, to have a red substance throughout, an empty container for liquids, and seven condiment cups unlabeled. In the freezer 12 dishes of ice cream were uncovered and unlabeled of which 2 dishes had spoons in the dish; 4 dishes of ice cream were covered, of</p> |   | <p>the following campus guidelines:<br/>1). Food Storage 2). Hair Restraints 3). Left over food 4). Food labeling 5). Cleaning schedule for refrigerator and freezers <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1). Audit of 5 opened food items to ensure the food is labeled properly. 2). Audit of the dry storage area to ensure only items belonging in this area are being stored here. 3). Observation of employees in the kitchen area to ensure hair nets are completely covering their hair. 4). Observation of all the nourishment refrigerator on the hallways to ensure that it is clean and all food items / containers / liquids are properly dated The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>which 2 were not dated.</p> <p>A copy of the policy and procedure was received on 3/4/13 at 7:42 p.m.. titled Food Storage and Hair Restraints from the Director of Nursing.</p> <p>3.1-21(i)(1)</p> |  |  |  |
|--|---|--|--|--|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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 |   |
| F000431<br>SS=E   | <p>483.60(b), (d), (e)<br/>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were labeled and</p> | F000431   | <p><b>F 431</b></p> <p><b>Corrective actions accomplished for those residents found to be affected</b></p>      | 04/03/2013           |   |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>disposed of in accordance with accepted standards of practice for 3 of 4 medication carts, 2 of 2 medication storage refrigerators, and 10 of 73 residents on Healthcare side. (Residents #103, #175, #23, #84, #85, #63, #52, #10, #68, and #13.)</p> <p>Findings include:</p> <p>During a medication cart observation on the 100 Hallway, on 3/4/13, at 2:55 p.m., with RN #1, it was observed to contain the following medications that had no labels, no opened date, or had expired:</p> <ul style="list-style-type: none"> <li>- For Resident #103: 1 opened over the counter bottle of Oscal (Calcium plus Vitamin D3) 500 mg (milligrams)/200 IU (international units) with no labeling at all.</li> <li>- For Resident #23: 1 opened bottle of Siltussin DM Cough Syrup with no opened date.</li> <li>- For Resident #84: 1 opened bottle of Lactulose 10 mg/15 ml (milliliter) with no opened date.</li> <li>- For Resident #85: 1 opened bottle of Megace ES 625 mg/5 ml with no opened date.</li> <li>- For Resident #13: 1 bottle of Promethazine 25 mg. Label indicated to discard by 1-10-13.</li> </ul> |   | <p><b>by the alleged deficient practice:</b> 1). The medications with no labeling, no opened date or expired date will be destroyed and new medications ordered for the following residents: #103, #23, #84, #85, #13, #63, #52, #175, #10, #68. 2). The expired opened vial of TB vaccine serum located in the 600 hallway med room refrigerator will be destroyed. 3). The expired opened vial of TB vaccine serum located in the med room refrigerator for 100/200/300 hallways will be destroyed. 4). The expired Promethazine 25 mg suppositories located in the med room refrigerator for 100/200/300 hallways for resident #10 will be destroyed and new medication ordered.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> An audit will be conducted of all opened medications on all medication carts and medication room refrigerators. Any medication that is noted to not be labeled, not have an open date or has an expired date will be destroyed and new medications will be ordered.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient</b></p> |  |  |   |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>On 3/4/13 at 3:30 p.m., with LPN #2, the medication cart for the 300 hallway was observed to contain the following medications with no opened date:</p> <ul style="list-style-type: none"> <li>- For Resident #63: 1 opened bottle of Torsemide HCL (Hydrochloride) 50 mg.</li> <li>- For Resident #52: 1 opened bottle of Milk of Magnesia.</li> </ul> <p>On 3/4/13 at 4:00 p.m., with LPN #2, the medication cart for the 200 hallway was observed to contain the following medications that had no labels, no opened date, or had expired:</p> <ul style="list-style-type: none"> <li>- For Resident #175: 1 opened bottle of Aspirin 325 mg and 1 open bottle of Citrical Plus D3 400 mg/500 IU with no name or labeling of any kind.</li> <li>- For Resident #10: 1 opened bottle of Docusate Sodium 150 mg/15 ml with no opened date.</li> <li>- For Resident #68: 1 opened bottle of Antacid tablets with expiration date of 12/11.</li> </ul> <p>On 3/4/13 at 4:20 p.m., with LPN #3, the medication room refrigerator for the 600 hallway was observed to contain 1 opened vial of TB (Tuberculosis) Mantoux vaccine</p> |   | <p><b>practice does not recur:</b> DHS or designee will re-educate the licensed nursing staff on the following: The campus guideline for Specific Medication Administration Procedures</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: DHS or designee will complete an audit of all opened medications on all med carts and med room refrigerators to ensure that labels, open date and no expired medications are in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/04/2013 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>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>serum that indicated on the box an open date of 1/25/13 and, "do not use 30 days after this date." The Medication room refrigerator for the 100, 200, and 300 hallways was observed to contain 1 opened vial of TB Mantoux vaccine serum that indicated on the box an open date of 1/28/13 and, "do not use 30 days after this date." Also observed Promethazine 25 mg suppositories that had expired on 2/13 for Resident #10.</p> <p>A policy and procedure for "Specific Medication Administration Procedures" was provided by the Director of Nurses on 3/4/13 at 5:37 p.m., and identified as their current policy. The policy indicated, but was not limited to, "when opening a multi-dose container, place the date on the container."</p> <p>3.1-25(j)<br/>3.1-25(l)(1)(2)(3)(4)(5)<br/>3.1-25(o)</p> |               |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2013

FORM APPROVED

OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155693 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                            | X3) DATE SURVEY<br>COMPLETED<br>03/04/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SILVER OAKS HEALTH CAMPUS |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2011 CHAPA DR<br>COLUMBUS, IN 47203   |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |