

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  10/11/2013
--	---	--	---

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
F000000	<p>This visit was for the Investigation of Complaint IN00137494.</p> <p>Complaint IN00137494 - Substantiated. Federal/state deficiencies related to the allegations are cited at F411 and F514.</p> <p>Survey dates: October 10 and 11, 2013</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Survey team: Jennifer Carr, RN, TC Diana Sidell, RN Sunny Jungclaus, RN (10/11/2013)</p> <p>Census bed type:</p> <p>SNF: 39 SNF/NF: 28 Residential: 34 Total: 101</p> <p>Census payor type:</p> <p>Medicare: 25 Medicaid: 18</p>	F000000	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 Complaint (IN00137494) Survey on ) October 11, 2013. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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  10/11/2013
--	---	--	---

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>Other: 58 Total: 101</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review on 10/17/2013 by Cheryl Fielden, 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  10/11/2013
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	
F000411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review and interview, the facility failed to provide routine dental services for 1 of 3 residents reviewed for routine dental care. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 10/11/13 at 9:30 a.m. The resident was originally admitted to the facility on 2/11/09. Diagnoses included, but were not limited to, cerebral palsy, diabetes, hypertension and dysphagia (difficulty swallowing). The resident's most recent Brief Interview for Mental Status (BIMS) score was 13 of 15 in July of 2013; which indicated he was cognitively</p>	F000411	F 411 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B - will interview resident and offer / recommend to schedule dental appointment. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents' medical records will be reviewed to compile a list of the last completed dental appointment for each resident. Any resident who has not had a follow-up or routine annual visit by a dentist in the last year, we will contact the resident and/or family for arrangement of dental services. Measures put in place and systemic changes made to ensure the alleged deficient	11/10/2013	

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  10/11/2013
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>intact.</p> <p>"Physician's Progress Notes" dated 7/26/11 indicated, "Cleaning/Dental Exam Brushing should be done at least 2xDay (two times per day). Decay found on #9 (tooth #9). Next appt. (appointment) 8/16/11 10:00 a.m. to restore #9." No further dental documentation was located in Resident #B's medical record.</p> <p>During a dining observation on 10/11/13 at 11:55 a.m., Resident #B was observed to be missing one upper front tooth. His remaining teeth were observed to be grey-brown in color.</p> <p>The Social Services Assistant provided a copy of Resident #B's "Health Services Consent Form", dated 5/11/09. She indicated that on-site dental care was "denied" by Resident #B's Power of Attorney (PoA) on the form. Regarding the 7/26/11 dental entry, she indicated, "They (the dentist) may see them once and that's it....It was one time only and the family wanted it...Or sometimes the communication isn't there from the dentist. Sometimes they don't follow up with us."</p> <p>Resident #B was interviewed on</p>		<p>practice does not recur: DHS or designee will re-educate the nursing staff on the following: 1). The campus guidelines for Oral Care. 2). DHS or designee will re-educate the Social Service Director or designee regarding record keeping of each resident's last dental appointment to ensure a process is in place to schedule and provide routine timely follow up and routine dental visits for all residents. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit will be conducted by the DHS or licensed designee 1 time per month (after each monthly dentist visit) times 6 months to ensure compliance: Complete an audit of the record keeping of each resident's last dental appointment to ensure no resident is out of compliance with their routine annual dental visits and that follow - up dental visits have been scheduled. 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:  155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

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>10/11/13 at 3:00 p.m., and asked if he sees a dentist. He indicated, "Not lately." Resident #B was asked why he had not seen a dentist. He indicated, "They haven't made an appointment in a while." Resident #B was asked if he would like to see a dentist. He indicated, "Yeah."</p> <p>In an interview with the Director of Nursing (DoN) on 10/11/13 at 3:30 p.m., she indicated that there was no further documentation regarding routine dental care or follow up in Resident #B's medical record. She further indicated, "We didn't have a dentist for a long time. The dentist we had retired."</p> <p>The policy for routine dental services was requested and the provided by the DoN. It was reviewed on 10/11/13 at 3:40 p.m. It included, but was not limited to:</p> <p>"2. SERVICES: ....B. <u>Services of Other Providers</u>. The facility makes available the services of other providers from whom the Resident may choose to receive services, including but not limited to pharmacy services...."</p> <p>3.1-24(a)(1)</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  10/11/2013
--	---	--	---

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

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  10/11/2013
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	
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to provide documentation of routine oral hygiene for those residents dependent on staff for activities of daily living for 3 of 3 residents reviewed for activities of daily living. (Residents #A, #B and #C)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 10/10/13 at 2:45 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, dementia with behavioral disturbances, macular degeneration with legal blindness,</p>	F000514	<p>F 514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident A, B, C - Oral care has been provided with am and pm care, and PRN and as per request of the resident. Documentation of routine oral hygiene will be located on the MAR (Medication Administration Record) for each resident. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Oral care has been provided with am and pm care, and PRN and as per request of the resident. Documentation of routine oral hygiene will be located on the MAR for each resident. Measures put in place and systemic changes made to</p>	11/10/2013	

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  10/11/2013
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>stroke, and anxiety.</p> <p>Resident #B's record was reviewed on 10/11/13 at 9:30 a.m. Diagnoses included, but were not limited to, cerebral palsy, diabetes, hypertension and dysphagia (difficulty swallowing).</p> <p>Resident #C's record was reviewed on 10/11/13 at 10:45 a.m. Diagnoses included, but were not limited to, weakness, dementia, hypertension, dysphagia (difficulty swallowing) and alzheimer's dementia with behaviors.</p> <p>The Director of Nursing (DoN) provided a copy of facility residents dependent on staff for activities of daily living (ADLs) on 10/10/13 at 11:15 a.m. Of the 37 residents listed, Residents #A, #B and #C were included.</p> <p>A copy of "Oral Care Guidelines" was provided by the DoN on 10/11/13 at 12:25 p.m. The policy includes, but is not limited to:</p> <p>"PURPOSE: To provide each resident with good oral hygiene....Oral hygiene is the practice of keeping the mouth and teeth clean to prevent dental problems and bad breath.... 8. Wet brush and put a small amount of toothpaste on the brush.</p>		<p>ensure the alleged deficient practice does not recur: 1). DHS or designee will re-educate the Nursing staff on the following campus guidelines: Oral Care. 2). DHS or designee will educate the nursing staff on the following: Oral care will be provided with am and pm care, PRN and as per request of the resident. Documentation of routine oral hygiene will be located on the MAR for each resident. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: 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 MAR for each resident selected to ensure that oral hygiene is provided and documented. 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:  155693		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
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>9. Clean entire mouth using gentle, back and forth strokes.... Procedure to be performed with am and pm care, PRN and as per request of resident."</p> <p>In an interview with CNA #1 10/11/13 at 3:10 p.m., she indicated that staff received an in-service on dental care "last week." When asked how often residents receive oral care, she indicated, "I'm not sure." Regarding Resident #B, she indicated, "It seems like he gets his at night."</p> <p>Documentation indicating evidence that oral care was provided according to the facility's policy and procedure for the previous 30 days was requested for Residents #A, #B and #C. The DoN provided documents entitled "CORP - ADL Detail Report" for each resident on 10/11/13 at 3:20 p.m. No oral care was documented for Resident #A, Resident #B or Resident #C.</p> <p>The DoN was interviewed on 10/11/13 at 3:30 p.m. She indicated that she was not aware what the policy indicated regarding frequency of oral care. She further indicated that oral care is documented under "personal hygiene" in the kiosk. She stated, "We do ADLs according to</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  10/11/2013
--	---	--	---

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>RAI (Resident Assessment Instrument) in the MDS (Minimum Data Set)." She further indicated that they do not specifically indicate oral care anywhere in the residents' medical record. On 10/11/13 at 5:05 p.m., she indicated that "being out on the floor and looking in their mouth" is the means by which she can be certain oral care is being provided despite it not being documented.</p> <p>3.1-50(1)</p>			