

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  08/21/2015
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NAME OF PROVIDER OR SUPPLIER  SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA STREET COLUMBUS, IN 47203
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180495.</p> <p>Complaint IN00180495 - Substantiated. State deficiencies related to the allegations are cited at R0006.</p> <p>Survey dates: August 20 and 21, 2015</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Census bed type: Residential: 31 Total: 31</p> <p>Sample: 3</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000		
R 0006  Bldg. 00	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</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.

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	<p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interview, the facility failed to provide adequate supervision for one resident who had three falls within a twenty-four hour period, resulting in an intracranial hemorrhage (Resident C).</p> <p>Findings include:</p> <p>On 8/20/2015 at 9:50 a.m., the Assisted Living (AL) Unit Manager indicated Resident C was not in the facility related to hospitalization following a fall. The AL Unit Manager indicated Resident C was ambulating "independently with her walker" prior to her recent hospitalization.</p>	R 0006	ROO06 - 1. Resident "C" returned to the Transitional Care Unit (skilled care) on 8-26-15 post hospitalization, and it is the intent that she will transition to the Legacy Lane Unit once therapy goals are met.2. All other residents residing on Assisted Living Unit will be assessed by the Director of Health Services, Assistant Director of Health Services, and the Assisted Living Unit Manager, via the Level Of Care Assessment, by 9-14-15, to ensure they meet the Assisted Living criteria as per guidelines and regulations. Any Residents that are identified as not meeting the regulatory requirements will be assisted with alternate placement, and relocation procedures will begin	09/15/2015

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	<p>On 8/20/2015 at 10:55 a.m., anonymous staff member # 1 indicated Resident C was "inappropriate" for the Assisted Living unit since her admission (November, 2014) related to her dementia and fall risk.</p> <p>Resident C's closed clinical record was reviewed on 8/20/2015 at 11:42 a.m. Diagnoses included, but were not limited to, dementia, difficulty in walking, weakness, gait abnormality, and history of falls. Resident C was admitted to the Assisted Living unit on 11/8/2014 following multiple falls at home. She ambulated with a walker.</p> <p>Resident C's Assisted Living Evaluation and Service Plan, dated 5/19/2015, included, but was not limited to, "...Kaleidoscope/Cognitive Level: Ruby - moderate.... Comments: Resident does not have cognitive function to know when to use call light."</p> <p>A Mental Health Wellness Circumstance Investigation for Resident C, dated 5/20/2015, indicated, "Type of incident: wandering...wondering [and] going in other residents' rooms. Diagnoses which may contribute to behavior: Dementia.... Mental Health Risk Re-Assessment: Resident has cognitive or memory impairment that effects behavior? Yes.</p>		<p>immediately.3..The Assisted Living Unit Manager was re-educated by the Director of Health Services and the Executive Director on 9-2-15, regarding the Assisted Living regulation as it pertains to AL criteria for placement and change in condition.4. The Director of Health Services and Assistant Director of Health Services will review Level Of Care Assessments monthly for six months to ensure all residents remain appropriate for residential care. The Quality Assurance Committee will review the results of all audits. The Committee will monitor the effectiveness and compliance with the plan, and update and develop plans of action to be carried out as indicated.</p>		

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	<p>Resident has difficulty understanding and following directions? Yes. Resident has a history of behaviors in the past three months? Yes. Resident has a diagnosis which contributes to behaviors? Yes...Identified behavior trigger which led to behavior concern? Yes...Resident has expanded ideation of time? (What seems like 20 minutes is in reality 2 minutes.) Yes. Resident doesn't comply with safety measures or other care plan interventions? Yes...."</p> <p>Resident C's Assisted Living Evaluation and Service Plan, last updated 7/15/2015, indicated the following regarding her care requirements: "Mobility: Requires supervision or escort...Hygiene/Dressing: Totally dependent on staff to dress, groom. Bathing: Totally dependent on staff for bathing...Toileting and Contenance Care: Incontinent, with assist of one...Sensory: Poor hearing with or without device. Activities: Requires staff assistance to manage time throughout 2-3 shifts daily. Requires staff 1:1 involvement for social involvement or individualized activities daily...Health Status: Unstable, nurse assessment. Grand Total Score: 33 Rose 25-39.9 [circled]...Kaleidoscope/Cognitive Level: Date: [blank/not indicated]..."</p> <p>Physician's Progress Notes, dated</p>			

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	<p>8/7/2015, indicated, "...Dementia slowly progressive...Family has decided to go ahead [with] move to Legacy [locked memory care unit]."</p> <p>Fall Circumstance Investigation, dated 8/14/2015 at 9:50 p.m., indicated, "...Location of fall: Resident's bathroom. Witnessed: No. Found on floor [check mark]. Injury: abrasion. Injury location: Res. [resident] back. Hit head [check mark]...Activity at time of fall: Toileting...Personal Inspection: Glasses not on, Toileting needs, Recent agitation or restlessness...Care Plan: ...I had a recent fall because: unbalanced gait. My goal is to: [blank]. Please help me by using/doing the following things: glasses in place, non-skid footwear, adequate lighting, call bell. IDT [Interdisciplinary Team] Review: Date: 8/17/2015. Root cause: Independent transfer [with] [no] socks or shoes. Intervention update appropriate: No. Change to: non-skid footwear...."</p> <p>The associated Fall Risk Re-Assessment indicated the resident had the following 11 of 13 fall risks included in the assessment: "cognitive or memory impairment that affects safety and judgement, difficulty in understanding and following directions, history of falls in past three months, requires assistance</p>			

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	<p>to ambulate safely with or without assistive device, resident has poor, impaired vision or forgets to wear glasses, unable to maintain balance while sitting, standing or walking without assistance, requires use of assistive device and/or often often forgets to use device, is taking psychoactive, diuretic, narcotic, analgesic, cardiovascular or anticonvulsive meds [medications], has loss of limb, vertigo [dizziness], hypotension, CVA [stroke], Parkinson's, seizures, arthritis, fx [fracture] or hx [history] of fx, MS [multiple sclerosis], Huntington's, refuses to comply with safety measures such as call light use, alarms, appliances, etc., resident is unable to maintain postural positioning in bed or chair."</p> <p>Nurse's Notes, dated 8/14/2015 at 11:00 p.m., indicated, "CNA [Certified Nursing Assistant] yelled for me to come to res. room. Heard a loud crash. Resident was lying in the bathroom floor between commode and sink. It was apparent that resident had hit her head from her position. [No] bumps [No] bruises [No] bleeding noted. Resident very drowsy [and] confused..."</p> <p>Fall Circumstance Investigation, dated 8/15/2015 at 6:00 a.m., indicated, "...Location of fall: [resident's room]."</p>			

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	<p>Witnessed: No. Found on floor [check mark]. Injury: bruising...skin tear. Injury location: [left] elbow. Hit head [check mark]. Lost consciousness: No...Treatment required: Yes. First Aid [check mark] MD [check mark] ER [check mark]. Describe: Resident fell walking to chair hit elbow...Non-verbal signs of pain: grimace/guarding. Location: back and hip [right]. Activity at time of fall: Ambulating. Personal Inspection: Assistive device not used...Other comments: Resident was walking to chair [and] wasn't using walker...Care Plan: Update [check mark]. I had a recent fall because [independent] ambulation [without] assistive device. My goal is to: not fall. Please help me by using/doing the following things: call bell. IDT [Interdisciplinary Team] Review: Date: 8/17/2015. Root cause: [Independent] ambulation [without] assistive device. Intervention update appropriate: No. Change to: sent to hospital R/T [related to] pain [and] hitting head. Other comments: staff to assist [with] morning ADLs [activities of daily living]."</p> <p>The associated Fall Risk Re-Assessment indicated the resident had the following 11 of 13 fall risks included in the assessment: "cognitive or memory impairment that affects safety and</p>			

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	<p>judgement, history of falls in past three months, requires assistance to transfer, requires assistance to ambulate safely with or without assistive device, resident has poor, impaired vision or forgets to wear glasses, unable to maintain balance while sitting, standing or walking without assistance, requires use of assistive device and/or often often forgets to use device, is taking psychoactive, diuretic, narcotic, analgesic, cardiovascular or anticonvulsive meds [medications], has loss of limb, vertigo, hypotension, CVA, Parkinson's, seizures, arthritis, fx or hx of fx, MS, Huntington's, refuses to comply with safety measures such as call light use, alarms, appliances, etc."</p> <p>Nurse's Notes, dated 8/15/2015 at 6:30 a.m., indicated, "Resident c/o [complained of] pain after hitting head on table and floor.... Resident showed nonverbal signs of face grimacing and guarding of the left side of her body...Dr. to send her to ER [Emergency Department] to be evaluated.... On inspection of [ambulance personnel] a bruise was found from the left shoulder down to her hip. When [ambulance] employee showed it, [Resident C] jerked back and tried to guard her side...."</p> <p>Hospital documentation indicated Resident C was discharged from the</p>			

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	<p>Emergency Department on 8/15/2015 at 11:14 a.m.</p> <p>Fall Circumstance Investigation, dated 8/15/2015 at 8:04 p.m., indicated, "...Location of fall: [resident room entry]. Witnessed: No. Found on floor [check mark]. Injury: bruising...skin tear. Injury location: forehead, [right] side of head, both hands. Hit head [check mark]. Lost consciousness: Yes (how long: unwitnessed)...Treatment required: Yes. First Aid [check mark], ER [check mark]. Describe: Stopped bleeding from head...Non-verbal signs of pain: grimacing. Location: Unresponsive. Activity at time of fall: Ambulating.... Care Plan: Update [check mark]. I had a recent fall because: I was ambulating alone [with] unsteady gait. My goal is to: not fall, reduce # [number] of falls, not be injured from fall. Please help me by using/doing the following things: ...Therapy evaluation, glasses in place, WC [wheelchair], other: send to ER. IDT [Interdisciplinary Team] Review: Date: 8/17/2015. Root cause: [Independent] ambulation [with] unsteady gait. Intervention update appropriate: Yes. Change to: therapy screen [and] eval [evaluation] [after] return from hospital."</p> <p>The associated Fall Risk Re-Assessment indicated the resident had the following</p>			
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	<p>12 of 13 fall risks included in the assessment: "cognitive or memory impairment that affects safety and judgement, history of falls in past three months, requires assistance to transfer, requires assistance to ambulate safely with or without assistive device, resident has poor, impaired vision or forgets to wear glasses, unable to maintain balance while sitting, standing or walking without assistance, requires use of assistive device and/or often often forgets to use device, is incontinent of bladder and/or bowel, is taking psychoactive, diuretic, narcotic, analgesic, cardiovascular or anticonvulsive meds [medications], has loss of limb, vertigo, hypotension, CVA, Parkinson's, seizures, arthritis, fx or hx of fx, MS, Huntington's, refuses to comply with safety measures such as call light use, alarms, appliances, etc."</p> <p>Nurse's Notes, dated 8/15/2015 [no time], indicated, "Resident had continued to be [up arrow] confused [and] unsteady since return from [hospital]. Writer was passing meds [at] nurse's station. Did not see Res. on couch where she normally sits. Went to check on res. in her room. Upon opening res. door found res. lying in the entry way on top of her walker. Resident was unconscious non-responsive for an unknown amount of time before I arrived. After verbally</p>			

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	<p>stimulating her for several minutes [and] trying to stop head from bleeding [and] hands, resident finally responded... Order to sent ER [Emergency Room]...."</p> <p>The following Nurse's Notes, dated 8/15/2015 at 9:50 p.m., indicated, "Rc'd [received] call from [hospital] that resident had a brain bleed and was being sent to [hospital]...."</p> <p>Emergency Department Physician Progress Notes, dated 8/16/2015, indicated, "History of Present Illness: fallen 3 times in last 24 hours...found down wrapped in her walker. Found to have Hematoma over forehead. HCT [head CT scan] found to have blood in occipital and temporal in R [right] lat [lateral] ventricle. Bruising throughout her body including bilat [bilateral] hands.... Physical Examination: ...Skin: ...Multiple bruising and abrasions on upper extremities as well as lower extremities.... ICU [Intensive Care Unit] was consulted and will admit the patient for close neurologic monitoring."</p> <p>On 8/21/2015 at 10:55 a.m., the Assistant Director of Nursing Services (ADNS) indicated Resident C's Power of Attorney/family requested Resident C be transferred to the Legacy Unit (secure memory care unit of the facility) on</p>			

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	<p>8/7/2015. The ADNS indicated Resident C was not transferred related to a room renovation on the Legacy Unit.</p> <p>A current copy of the Falls Management Program Guidelines Policy and Procedure was provided by the ADNS on 8/20/2015. The ADNS indicated the Policy and Procedure was the same for all units in the facility, including Assisted Living. The Procedure indicated, "...1.a. Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. b. Care plan interventions should be implemented that address the resident's risk factors.... 3. Should the resident experience a fall the attending nurse shall complete the 'Fall Circumstance and Reassessment Form.' The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode.... 4. An 'Accident and Incident Report' should be completed at the time of the incident.... 8. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...."</p> <p>On 8/20/2015 at 2:41 p.m., the Director of Nursing Services (DNS) declined to</p>			

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	<p>provide documentation of the Accident and Incident Reports for any of Resident C's three falls (above).</p> <p>On 8/21/2015 at 10:55 a.m., the DNS indicated Resident C had a "general decline" since July, 2015. The DNS indicated, "I would not have considered [Resident C] high risk [for falls]." The DNS indicated there was no evidence of documentation between her return to the facility following the second fall and prior to the third fall.</p> <p>A current copy of Assisted Living Guidelines for Evaluation and Service Plan Policy and Procedure was provided by the DNS on 8/20/2015 at 1:45 p.m. The procedure indicated, "...5. The resident's functioning and needs shall be within the state requirements for admission and continued stay.... 7. A level of care score shall be assigned based on the identified functioning level and needs. a. Jade 0-15. b. Gold 16-30. c. Rose 31-55. d. Royal 56-116...."</p> <p>A current copy of Resident Move-in Agreement, was provided by the DNS on 8/21/2015 at 9:44 a.m. The agreement indicated, "...6. Termination, Transfer, or Discharge...B. Initiated by Facility. The Facility may terminate this agreement and the Resident's stay, and transfer or</p>			

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	<p>discharge the Resident if: (1) The transfer or discharge is necessary to meet the Resident's welfare and the Resident's needs cannot be met by the facility...."</p> <p>A current copy of Assisted Living Guidelines Discharge Due to Level of Care Change Policy and Procedure was provided by the DNS on 8/21/2015 at 9:44 a.m. The Procedure indicated, "Purpose: To ensure residents are in an appropriate care setting to provide for their needs. Procedure: ...2. The resident shall seek alternate placement if: a. They become a danger to their self or others. b. Requires 24 hour per day comprehensive nursing care or oversight...."</p> <p>This State tag relates to the Investigation of Complaint IN00180495.</p>			