

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2014
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NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203
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F000000	<p>This visit was for the Investigation of Complaint #IN00139787.</p> <p>Complaint #IN00139787 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F253</p> <p>Survey dates: February 24, 2014 and February 25, 2014</p> <p>Facility number: 002955 Provider number: 155693 AIM number: 200346570</p> <p>Survey team: Jennifer Carr, RN - TC</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 27 Medicaid: 18 Other: 24 Total: 69</p> <p>Sample: 3</p> <p>Supplemental sample: 3</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 Complaint (IN00139787) Survey on February 25, 2014. 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.</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>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on March 3, 2014 by Cheryl Fielden RN.</p>			

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F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	CORRECTIVE ACTIONS	03/27/2014			

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	<p>Based on interview and record review, the facility failed to immediately report allegations of abuse in accordance with State law through established procedures (including to the State survey and certification agency) and provide evidence that it thoroughly investigated allegations of abuse for 2 of 3 residents reviewed for abuse. This deficient practice had the potential to impact all 69 residents in the facility.</p> <p>Findings include:</p> <p>A copy of the facilities "Grievance and Complaint Log" for the dates 7/14/2013 through 12/30/2013 was provided by the Director of Health Services (DoHS) on 2/24/2014 at 11:20 a.m. She indicated that the facility had no "reportable incidents of alleged abuse" in the past six months.</p> <p>Resident Council Minutes for the previous six months were provided for review by the Activities Director on 2/25/2014 at 12:15 p.m. At that time, she indicated that the facility elected not to have a Resident Council President. There was no documentation indicating abuse or neglect.</p>		<p>ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:There were no adverse outcomes to any of the residents as a result of the alleged deficient practice. No residents were affected. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents have the potential to be affected by the same alleged deficient practice. Through systemic changes stated below, we will ensure the campus will provide a safe environment. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Mandatory in-service for all facility staff on Abuse and Neglect Procedural Guidelines (attachment 1), and Reportable Event Procedure Guidelines (attachment 2). In-services given 2-27-14 and 2-28-14. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: Educate all facility staff on Abuse and Neglect Procedural Guidelines and Reportable Event Procedure</p>				

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	<p>The DoHS was interviewed regarding the policy and procedure for reporting and investigating allegations of abuse on 2/25/2014 at 10:55 a.m. She indicated, "Sometimes staff doesn't report until their shift is over and then they're gone. Then we just investigate it." When queried as to reporting the alleged abuse to Indiana State Department of Health (ISDH), she indicated, "It would depend on my investigation...If I investigate and figure it out within 24 hours, usually less, that it 's an issue, I report it. If not, I don't."</p> <p>The DoHS was asked if the facility had any incidents in the last six months which "may have potentially been considered abuse", were investigated, but not reported, she indicated, "No."</p> <p>During an interview with the Director of Social Services on 2/25/2014 at 12:45 p.m., she indicated, "If an abuse situation occurs, I investigate, write it all down and give it to [DoHS] and [Executive Director]." She indicated that she did not know of any reportable allegations of abuse occurring in the facility in the last six months. When asked if she had</p>		<p>Guidelines at new hire orientation and twice yearly. Written pre-post test will be administered on Abuse and Neglect and Reportable Events with in-service upon new hire orientation and twice yearly. (attachment 3) All Incident/Accident reports will be reviewed by DHS/Designee each month to ensure Abuse/Neglect Procedures and ISDH Reportable Procedures are being followed. These reports will be reviewed in QA meeting every month for 6 months. Completion Date: March 27, 2014</p>				

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	<p>looked into any instances which may have been considered abuse, but were determined not to be abuse following investigation, she indicated, "I've interviewed 2 residents on a few incidents." She was not able to recall any specific details.</p> <p>The Executive Director was interviewed on 2/25/2014 at 2:25 p.m. regarding the abuse policy and procedure. He indicated, "If there's any question, we investigate it as abuse." He further indicated that there had been no allegations of abuse in the last six months. When asked if there were any incidents since the last recertification survey (March, 2013) which "may have potentially been considered abuse", were investigated, but not reported, he indicated, "You'd have to ask [DoHS]. She may have a soft chart."</p> <p>The DoHS was interviewed on 2/25/2014 at 3:18 p.m. She indicated, 'I would ask that staff member to put it in writing. Social Services would write it up. I would check to see if anyone overheard it. And then if we determine that it was abuse, you [sic] would report it to state right away. If it wasn't abuse, I would council that employee so they</p>						

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	<p>understand what abuse is."</p> <p>During an interview with the Assistant Director of Health Services (ADoHS) on 2/25/2014 at 4:30 p.m., she indicated that any suspicion of abuse would "become an allegation (of abuse)". She indicated that the employee involved would be suspended pending investigation. She further indicated, "Then we would report it because it was proven to be abuse or, if we found that it wasn't proven, we would provide teachable moments, in-service...we'd do that either way." When asked if there had been any incidents in the last six months "may have potentially been considered abuse", were investigated, but not reported, the ADoHS indicated, "Yes. We had a student (Student Certified Nurse Aide) with a CNA (Certified Nurse Aide)...it was the CNA with the way she was talking to another resident. It was investigated with statements. She then provided Resident D's name. She further indicated, "There was one other one...a resident-to-resident months and months ago. She then provided Resident E's name.</p> <p>On 2/25/2014 at 4:45 p.m., the DoHS was asked to provide any</p>			

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	<p>reportable allegations of abuse, "soft charts", and/or "grievances" since the last recertification survey (March, 2013).</p> <p>A copy of "Indiana State Department of Health Incident Report Form; Unusual Occurrence / Initial with Follow-up." for Resident E, dated 6/26/2013, was provided by the DoHS on 2/25/2014 at 4:40 p.m. The document included, but was not limited to, "Brief description of Incident: [Resident D] pulled privacy curtain back and hit [Resident G] multiple times on left arm and back with lift chair remote." No written statements, evidence of investigation, or evidence of follow-up were included. During an interview with the DoHS on 2/25/2014 at 4:43 p.m., she indicated, "We can't find the rest of it."</p> <p>A copy of "Indiana State Department of Health Incident Report Form; Unusual Occurrence / Incident", "Indiana State Department of Health Incident Report Form; Follow-up Report", and investigative documentation for Resident F, for an incident occurring 3/16/2013, were provided by the DoHS on 2/25/2014 at 4:48 p.m. A review of these</p>						

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	<p>documents indicated no findings.</p> <p>A 5 page, stapled document on plain paper was provided by the DoHS on 2/25/2014 at 4:50 p.m., which she indicated was the " soft chart " for an incident involving Resident #D. The document indicated, in full, the following:</p> <p>1) Page 1 (typed on plain paper and signed by the DoHS): "2/14/2014. Upon initial allegation of verbal abuse by CRCA [Certified Nurse Aide], [CNA #3] toward resident [Resident #D], [CNA #3] was suspended and sent home pending investigation. After investigating issue r/t [related to] alleged abuse, along with IDT [inter-disciplinary team] and clinical support, it was determined that CRCA [CNA #3] was not verbally abusive to resident. Statement was obtained from C4 student [Student CNA] [Student CNA #4] stating she was present with care of [Resident #D] during time of alleged abuse and witnessed no abusive language by [CNA #3]."</p> <p>2) Page 2 (hand-written on plain paper and signed by Student Nurse #4): "We were trying to get</p>						

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	<p>[Resident #D out of his chair and into his bed using the hoyer [Hoyer lift]. [CNA #3] was saying that he was stiffening up a lot today. She told him she was going to get [LPN #6] and [RN #5] to help if he stiffened or was starting to slide down in his chair. I felt that [CNA #3] was being playful with [Resident #D] and I wouldn't think she'd ever threaten a patient."</p> <p>3) Page 3 (hand-written on plain paper and signed by CNA #3): "I did playfully say to [Resident #D] Hey buddy me and you can't do this today, I can't have you falling on me hunny [sic], or I'll have to get help [RN #5] and [LPN #6] I'm sure they xxx [illegible] xxx [illegible] on me ha ha."</p> <p>4) Page 4 (hand written on plain paper and signed by the Activities Director): "On Feb 14th, 2014...I overheard a CNA ([CNA #3]) talking to a Resident in a way that concerned me. [CNA #3] said, 'Don't be giving me no problems, you hear me, or I'll go get [RN #5] and she named another person and they won't be nice to you, you know that!' She then proceded [sic] to say I don't have time for this, I'm trying to get home to my little girl! There</p>			

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	<p>was another student CNA in the room with [CNA #3] at the time."</p> <p>5) Page 5 (hand-written on plain paper and signed by Activities Assistant #1): "2/14/2014. On 2/14/2014 at about 12:30 in the afternoon I was in 300 hallway...I and another co-worker overheard a CNA named [CNA #3] talking to [Resident #D] in his room. She said 'Don't be givin [sic] me no problems or I'll get [RN #5] and someone else to come in here. And they won't be nice to you.' Then she said, 'I don't have time for this. I got a daughter to go home to.' There was a student in there helping her and heard the whole thing."</p> <p>A copy of "Abuse and Neglect Procedural Guidelines" was provided by the Director of Health Services (DoHS) on 2/24/2014 at 11:20 a.m. The policy and procedure included, but was not limited to, the following:</p> <p>1) "The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures."</p> <p>2) "ABUSE means the <u>willful</u></p>						

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	<p>infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged) ...This presumes the instance of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish. "</p> <p>3) "Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal."</p> <p>4) "The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows:</p> <ul style="list-style-type: none"> • Immediately notify the Executive Director. If the Executive Director is absent, they may appoint a designee. • The Executive Director or designee must notify the resident(s)' physician(s)' and family/responsible party. • Complete an Accident and Incident Report. Refer to the Accident and Incident Program regarding investigation procedures. 			

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	<ul style="list-style-type: none"> • The Executive Director is responsible for: <ol style="list-style-type: none"> 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services, and/or local law enforcement agencies, as indicated." 5) "The Executive Director is accountable for investigating and reporting." 6) "Immediately and not more than 24 hours complete an initial report to applicable state agencies." 7) "A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days." 8) "The investigation folder and Episodic Event Forms should be completed for all state reportable occurrences." 				

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	<p>During an interview with the DoHS, ADoHS, and RN #7 on 2/25/2014 at 4:45 p.m., the DoHS indicated that she determined after interviewing Student CNA #4 and CNA #3 (the alleged perpetrator) that the alleged abuse to Resident #D did not occur. She further indicated, "I'm not going to call it abuse based on someone hearing part of a conversation walking down the hall." She further indicated that she did not report the incident to the Indiana State Board of Health or follow up further. Se further indicated that there was no additional documentation related to the 2/14/2014 incident involving Resident #D. The DoHS, ADoHS, and RN #7 all indicated that the statements/allegations by the Activities Director and Assistant Activities Director would qualify as an allegation of verbal abuse/intimidation.</p> <p>3.1-27(a)(b) 3.1-28(c)(d)(e)</p> <p>This federal tag relates to Complaint #IN00139787.</p>				

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F000253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and sanitary environment in that 30 of 34 resident bathroom vents and all the vents in the main dining room were observed to be dirty (Rooms 105, 107, 108, 109, 111, 112, 114, 207, 208, 209, 210, 303, 304, 305, 306, 401, 402, 406, 407, 409, 601, 604, 607, 608, 611, 612, 613, 614, 616, and 617). This deficiency had the potential to impact all 69 residents in the facility.</p> <p>Findings include:</p> <p>An environmental tour was conducted with the Assistant Director of Health Services (ADoHS) on 2/24/2014 at 11:25 a.m. 30 of 34 resident bathrooms observed, in various locations of the facility, had varying amounts of dust and/or a brown-grey substance on them. 8 of 8 vents in the main ("T.C.S.") dining room were observed to have varying</p>	F000253	<p>CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:No residents suffered any ill effects from the alleged deficient practice.IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents have the potential to be affected by the same alleged deficient practice. Through systemic changes stated below, we will ensure the campus will provide a safe, clean, comfortable and home-like environment.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Systemic changes are:Exhaust fans located in resident bathrooms will be removed and cleaned. The air duct vent grills in the common areas will be soaked and cleaned. The vent grills will be painted if necessary. Plant</p>	03/27/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2014
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>amounts of dust and/or a brown-grey substance on them.</p> <p>During an interview with the Director of Plant Operations, on 2/24/2014 at 11:54 a.m., he indicated that housekeeping is responsible for cleaning the vents in resident bathrooms.</p> <p>During an interview with the Director of Environmental Services, on 2/24/2014 at 12:05 p.m., she indicated, "Maintenance does it (clean the vents in resident bathrooms), but we spot-check."</p> <p>During an interview with the ADoHS on 2/24/2014 at 11:59 a.m., she indicated, "Looks like there's some miscommunication there."</p> <p>The following Housekeeping and Plant Operations (maintenance) policies, procedures, and logs were provided by the Executive Director on 2/25/2014 at 11:31 a.m.:</p> <ol style="list-style-type: none"> 1) "Environmental Policy and Procedures: Room Cleaning" 2) "Environmental Policy and Procedures: Common Areas" 3) "Housekeeping Log" 4) "Cleaning Log" 5) "Trilogy Daily Rounds" (Plant 		<p>Operations will clean these every six months and earlier if identified by Housekeeping Staff as a result of their daily rounds. Housekeeping Staff will dust the outside of the exhaust fans and vents daily as part of their Routine Daily Assignments, and as needed. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: Director of Plant Operations/Designee will complete environmental rounds and document that they have inspected the exhaust fans and air duct grills 3 days per week for 4 weeks, weekly for 4 weeks, and monthly for 6 months. (attachment 4). Findings will be reviewed at the QA Committee meeting for 8 months. This will ensure that the exhaust fans and air duct grills remain clean. Completion Date: March 27, 2014</p>		

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	<p>Operations)</p> <p>6) "Trilogy Common Area Monthly PM Inspection Sheet" (Plant Operations)</p> <p>The "Housekeeping Log" indicated, "Monthly: Common area vents dusted." Resident room/bathroom vents were not addressed in any of the policy and procedures (above) reviewed.</p> <p>During an interview with the Executive Director on 2/24/2014 at 5:10 p.m., he indicated, "I would agree" that resident room/bathroom vents were not addressed in any of the facility policies and/or procedures. He further indicated, "I'm going to have both of them (Housekeeping and Plant Operations) doing it."</p> <p>3.1-19(f) This federal tag relates to Complaint #IN00139787.</p>			
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