

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for the Investigation of Complaint IN00131832.</p> <p>Complaint IN00131832 Substantiated - State finding related to the allegations is cited at R90.</p> <p>Survey dates: July 22 and 23, 2013</p> <p>Facility number: 002512 Provider number: 155671 AIM number: 200278690</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 29 SNF/NF: 49 Residential: 21 Total: 99</p> <p>Census payor type: Medicare: 16 Medicaid: 43 Other: 40 Total: 99</p> <p>Sample: 4</p> <p>This state finding is cited in</p>	R000000		
---------	---	---------	--	--

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: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
(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	
	accordance with 410 IAC 16.2.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013	
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586			
(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			
R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to ensure 2 allegations of abuse by a physical therapist and 2 nurses were thoroughly investigated and/or reported to the Indiana State Department of Health [ISDH] within 24 hours, for 1 of 4 residents reviewed for abuse in a sample of 4. Resident B</p> <p>Findings include:</p> <p>1. On 7/22/13 at 10:05 A.M., during interview with Family # 1, she indicated she was visiting Resident B in March 2013, and observed a large hematoma (raised bruise) on the back of Resident B's knee. Family # 1 indicated she asked Resident B what had happened, and Resident B informed her that Physical Therapist (PT) # 1 had came into her room, and "acted like she was angry." Resident B indicated, "[PT # 1] grabbed my knee and squeezed it very hard." Resident B indicated to Family # 1</p>	R000090	<p>Please accept this Plan of Correction which constitutes our compliance of R090</p> <p>We cordially request a desk review</p> <p>How we corrected</p> <p>Immediately after being notified of allegations of abuse by the state surveyor, an investigation was initiated and reported to state department of health. The investigation concluded that no abuse or harm had accrued. The resident stated that no one abused her in any way and that she didn't feel threatened by anyone.</p> <p>Others effected</p> <p>Other clients had the potential to be effected. All clients were interviewed and no form of abuse was noted to occur with the client nor have they seen any other form of abuse occur to others within the campus.</p> <p>Steps taken to halt reoccurrence</p> <p>Policy/Procedures were reviewed on abuse reporting, and all staff were in serviced on abuse reporting.</p> <p>How Monitored</p> <p>Administrator will follow up on all allegations and forward to QA monthly for review x 12 months</p>	08/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
(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>that she asked PT # 1 to stop, "but she didn't listen." Family # 1 indicated she was concerned, and spoke to LPN # 1 regarding physician notification and the treatment of the hematoma.</p> <p>Family # 1 indicated that was on a Friday, and she called again on that Monday and spoke to the Director of Nursing (DON) regarding her concerns of how the hematoma occurred. Family # 1 indicated the DON informed her she would "look into it."</p> <p>Family # 1 indicated 2 1/2 weeks later, she had not heard anything.</p> <p>Family # 1 indicated she spoke to a corporate "peer review" staff member, and expressed her concerns regarding the hematoma. That staff member indicated she would look into it. Family # 1 indicated she received a call the next day, and 4 facility staff members were on a teleconference call. She indicated the staff members informed her that no wrong-doing was found, and "medical protocol was followed." Family # 1 indicated that was on April 10.</p> <p>Family # 1 indicated she later called the corporate hotline, and was going to voice concerns over other issues besides the hematoma. She indicated she received a phone call from</p>		<p>Follow up with resident and family weekly for the first 30 days, every other week for 60 days, then quarterly thereafter. Any concerns will be addressed with the administrator, DHS and Family to resolve these issues.</p> <p>Date of compliance: 8-2-13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>(Corporate Director # 1) who informed her that "we did find wrong-doing" regarding the development of the hematoma, and "serious corrective action" had been completed.</p> <p>On 7/22/13 at 11:30 A.M., the Director of Nursing provided a list of residents, indicating which residents were interviewable. Resident B was listed as interviewable.</p> <p>On 7/22/13 at 11:50 A.M., during interview with Resident B, she indicated her "left knee isn't as good as it was before" the physical therapist worked with her. Resident B indicated it "felt like she grabbed too hard. I asked her to stop but she didn't." Resident B indicated the bruise was "very noticeable," and she told her daughter what had happened.</p> <p>The clinical record of Resident B was reviewed on 7/22/13 at 2:20 P.M.</p> <p>An "Evaluation and Service Plan," dated 3/21/13, indicated the resident was "Alert, oriented, makes independent decisions," and had "No problems, deals with emotions and situations in a socially acceptable manner."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>Nurses Notes included the following notations:</p> <p>2/28/13, untimed: "Order received for PT [physical therapy] to tx [treat] 5 x wk x 30 days...."</p> <p>3/13/13, untimed: "Resident has small pockets of fluid behind bilateral knees...."</p> <p>3/15/13, untimed: "MD notified of large bruise/hematoma behind [left] knee. Awaiting response."</p> <p>3/16/13 at 5:15 P.M.: "Called on call M.D. for hematoma behind [left] leg. Resident refuses to go to ER. Family here and are concerned M.D. will call back...Is very dark in color. Meaures 9 cm [centimeters] W [width] x 12 cm L[length]."</p> <p>3/16/13 at 5:20 P.M.: "Family very rude et [and] yelling @ staff saying we caused this et we should have taken care of it days ago."</p> <p>3/16/13 at 6:00 P.M.: "M.D. returned call. N/O [new order] for heat 15 mins a day to affected area et wrap [with] ace bandage for day or two...."</p> <p>3/28/13 at 1:15 P.M.: "Resident c/o [complains of] [increased] pain to left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013	
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586			
(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>leg behind knee. Area has fading bruise [with] dark area located [left] outer center. Area hard to touch, [with] puffiness noted. MD notified...."</p> <p>On 7/23/13 at 10:55 A.M., during interview with the Corporate Nurse, she indicated the previous DON had informed her that Resident B had developed the hematoma behind her left knee, and that Resident B indicated, "She had some discomfort after physical therapy." The Corporate Nurse indicated she instructed the DON to go and speak to Resident B and ask her if she had been mistreated or abused, and the Resident "never said she was abused, so there was no investigation into abuse, and nothing was reported [to the ISDH]." The Corporate Nurse indicated PT # 1 was no longer employed at the facility, but that it had "nothing to do with this lady." The Corporate Nurse indicated the 9 cm x 12 cm bruise "was not that big." The Corporate Nurse indicated the Corporate Physical Therapist had investigated the concern.</p> <p>At that time, the Executive Director provided a document, dated 3/18/13, and signed by the Corporate Physical Therapist. The document indicated, "Customer concern...[Resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>B)...Concern: DHS [Director of Health Services] reports that pt [patient] family has called and voiced concern that pt experienced discomfort with therapy treatments. Investigation of concern: Spoke with [Resident B]. Pt. reports she had discomfort in her knee with PT during treatment. She asked PT at that time to stop the treatment. PT stopped the joint mob [mobility] treatment at that time...Pt. notes that she has a bruise on her knee. This writer performed an investigation and assessed the knee. ROM [range of motion] and strength were fine and painless. Pt. reported that she bruises easily. Pt asked to discontinue PT, Pt was discharged from PT treatments this date."</p> <p>On 7/23/13 at 1:30 P.M., during interview with the Executive Director, he indicated he had spoken to the previous DON, who was now Corporate staff, and she thought she had written notes regarding her conversation with Resident B. The Executive Director indicated he was unable to locate the notes.</p> <p>The Executive Director also indicated at that time that PT # 1's termination date was 3/22/13, and he thought the reason was for "customer service" issues.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>2. On 7/22/13 at 10:05 A.M., during interview with Family # 1, she indicated the following: On approximately 6/24/13, LPN # 2 was administering medication to Resident B, and "thought she saw [Resident B] slip a pill out." Family # 1 indicated she received a phone call from Resident B, and heard "all this yelling going on." Resident B indicated, "They think I took a pill." She indicated LPN # 2 "took the phone" from Resident B. She indicated she heard LPN # 1 in the background. Resident B informed Family # 1 that "they [LPN # 1 and LPN # 2] came charging into the room." Resident B had been up with her walker and was trying to enter the bathroom. Resident B indicated LPN # 2 was holding on to the door, not letting Resident B close the door, and Resident B was trying to close the door. Family # 1 indicated, "She just gave up and went back to her chair and that is when she called me."</p> <p>Family # 1 indicated she informed LPN # 2 to "just get out of her room and leave her alone." Family # 1 indicated Resident B informed her the next day that the DON came into her room, and "threatened her, they would search the room from top to bottom."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>Family # 1 indicated she called the DON, and "begged her, don't threaten her, just talk to her." Family # 1 indicated the DON "honored my request."</p> <p>Family # 1 indicated Resident B had Tylenol at her bedside, and didn't know she wasn't allowed to have Tylenol. Resident B "handed the Tylenol over." Family # 1 indicated Resident B "felt scared and intimidated." Family # 1 indicated she did speak to the Corporate Nurse "for a long time" about all of these issues.</p> <p>On 7/22/13 at 11:50 A.M., during interview with Resident B, she indicated she "didn't know I couldn't have Tylenol."</p> <p>She indicated she had a "little pill box, and LPN # 2 saw me put a pill in there. Then [LPN # 1 and LPN # 2] barged in and demanded for me to give them my pill box. It's my room and I refused. Then I tried to shut my door, and they were both tugging on the door so I wouldn't shut it. Then I called my daughter and they left. The next day, the [DON] came in." Resident B indicated, "I know my rights." Family # 2, who was present during the interview, indicated he felt "like it could have been handled better. Why would they be tugging at the door when she's up with a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>walker?"</p> <p>The clinical record of Resident B was reviewed on 7/22/13 at 2:20 P.M.</p> <p>"Evaluation and Service Plans, dated 3/21/13, 4/11/13, and 7/5/13, indicated the resident was "Alert, oriented, makes independent decisions," and had no mood or behavior problems.</p> <p>Nurses Notes included the following notations:</p> <p>6/24/13 at 7:40 P.M.: "Went in to give client her bedtime pills. I looked in the cup and realized I didn't put her antibiotic in the cup...I will be right back. Upon re-entering the room I witnessed the client putting a round white pill from her mouth into a tin in her lap. I ask her 'What is that?' she says, 'Oh, I keep Tylenol in my room.' I said [Resident B], from my understanding we are not allowed to keep meds in our room. May I see it? She stated no its none of your business. At this time I went to health one to get another nurse to see if she would let them see. Client gets irritated and yelling 'no you can't see what's in this tin you can see my Tylenol, which she has a full bottle in her room. I told nurse to stay [with]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(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>her while I go call the DHS to see what she wants me to do in this situation. I leave to call the DHS. The nurse that is still in the room witnessed client going to the toilet [with] the tin trying to flush the contents down the toilet. When I enter the room at this time client has called her daughter...The nurse [LPN # 1] is on the phone [with] her she is telling her if it is a narcotic which a sleeping pill is we really need to investigate. I can hear the daughter yelling at her through the phone. I take the phone from the nurse...I tell her well I have notified the DHS and she will handle this situation tomorrow. She states yelling 'Yes, that's right if you have my mother upset to the point of fussing and yelling you get out of her room right now...."</p> <p>6/25/13 at 8:00 A.M.: "This nurse...spoke [with] resident about her concerns from 6/24/13, resident states, 'I know my rights and I know I can keep Tylenol in my room and your nurses said I can't.' This nurse apologized to resident that she was upset...Resident then handed this nurse a bottle of Tylenol...."</p> <p>6/25/13 at 2:00 P.M.: "Resident POA [name] returned call @ this time [name] voiced concerns r/t [related to]</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013	
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586			
(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>nursing staff 'searching' resident's room et refusing to allow her to keep her meds in her room..."</p> <p>On 7/23/13 at 9:40 A.M., during interview with the DON, she indicated she did not have an investigation into alleged abuse, but that she documented in the resident's chart.</p> <p>On 7/23/13 at 10:55 A.M., during interview with the Corporate Nurse, she indicated the incident involving the medication was not investigated as alleged abuse or reported to the ISDH. The Corporate Nurse indicated her understanding was the resident was upset because she wanted to keep pills in her room. The Corporate Nurse indicated it was her understanding that the resident "never accused the nurses of being appropriate."</p> <p>At that time, the Executive Director indicated he had not received any allegations of abuse against either LPN # 1 or LPN # 2, and so it wasn't reported to the ISDH.</p> <p>3. On 7/22/13 at 11:30 A.M., the Executive Director provided the current facility policy on "Abuse and Neglect Procedural Guidelines," revised 9/16/10. The policy included:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...The Executive Director is accountable for investigating and reporting...Immediately and not more than 24 hours complete an initial report to applicable state agencies...."</p> <p>On 7/23/13 at 9:20 A.M., the DON provided the current facility policy on "Reportable Event Procedural Guidelines," dated 11/2010. The policy included: "Purpose: To provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines. Procedure: 1. Occurrences to be report [sic] include: a. Mistreatment b. Abuse c. Neglect...e. Injuries of unknown origin (may be determined as abuse/neglect)...i. Significant injuries (Contact your Divisional Nurse to discuss injury on an individual basis)...iii. Large lacerations or contusions [bruising] (of unknown origin or requires hospitalization >23</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
(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>hrs.)...2. The campus shall complete the appropriate 'State Reporting Form' and send to the State Agency within 24 hours of the incident discovery...."</p> <p>On 7/23/13 at 1:30 P.M., the Executive Director indicated these policies included both the "Assisted Living" and "Health Care" units.</p> <p>This state finding related to Complaint IN00131832.</p>				

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

PRINTED: 08/07/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586		
(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	