STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 00 B. WING	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey, and the Investigation of Complaints IN00430897, IN00431864, IN00431890, IN00432712, IN00432795, and IN00433027 Complaint IN00430897 - Federal/State deficiency related to the allegation is cited at F687. Complaint IN00431864 - Federal/State deficiency related to the allegation is cited at F687. Complaint IN00431890 - No deficiencies related to the allegation was cited. Complaint IN00432712 - Federal/State deficiency related to the allegation is cited at F677. Complaint IN00432795 - No deficiencies related to the allegations were cited. Complaint IN00433027 - Federal/State deficiency related to the allegation is cited at F684. Survey dates: April 29, 30, May 1, 2, 3, 6, and 8, 2024 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 25 SNF: 28 Residential: 27 Total: 80	F 0000	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 to respond to the allegations of noncompliance cited during the Complaint Survey conducted May 8, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 30, 2024. The provider respectfully requests 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
Pamela Cole	Executive Director	05/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Census Payor Type: Medicare: 19 Medicaid: 20 Other: 14 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 14, 2024			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to provide bathing for 2 of 3 dependent residents reviewed for Activities of Daily Living. (Residents C and D) Findings include: 1. During an interview on 05/06/24 at 2:34 P.M., QMA (Qualified Medication Aide) 10 indicated residents were to be offered showers at least twice a week but could have more if requested. The showers were given on dayshift and evening shift. The bathing was to be documented in the electronic record and they were to fill out a skin sheet on each resident after bathing. The skin sheets were signed by the nurse and then given to the ADON (Assistant Director of Nursing). During an interview on 05/06/24 at 2:50 P.M., CNA Student (Certified Nurse Aide Student) 8 indicated If a resident refused a shower, she would offer to	F 0677	1. Residents C and D were affected by alleged deficient practice. No adverse effects noted. 2. All residents have the potential to be affected. Licensed staff educated on ADL care. 3. As a measure of ongoing compliance, the DHS or designee will monitor that showers are being offered and provided according to policy. Audit to consist of three residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	05/30/2024

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	give them a bed bath and document the refusal of bathing or the type of bathing in the computer charting. The clinical record for Resident C was reviewed on 05/02/24 at 3:02 P.M. An Admission MDS (Minimum Data Set) assessment, dated 04/03/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, hypertension, heart failure, diabetes, malnutrition, anxiety, and depression. The Point of Care History and the Shower Sheets indicated the resident had the following showers or complete bed baths since admission to the facility on 03/29/24: - 04/03/24, shower, - 04/06/24, complete bed bath, - 04/13/24, shower, - 05/01/24, shower, - 05/04/24, refused, and - 05/05/24, complete bed bath. The resident had only received 6 of 20 scheduled showers or complete bed baths since admission. There was only one documented resident refusal of a scheduled shower or complete bed bath. 2. The clinical record for Resident D was reviewed on 05/06/24 at 9:38 A.M. An Admission MDS assessment, dated 03/04/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, anemia, diabetes, and malnutrition. The Point of Care History and the Shower Sheets indicated the resident had the following		Improvement meetings. The plan will be reviewed and updated as warranted.	

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	showers/bathing from admission to the facility on 02/27/24 until discharge on 03/30/24: - 02/28/24, shower, - 03/08/24, shower, - 03/11/24, shower, - 03/13/24, shower, - 03/18/24, shower, - 03/23/24, lack of documentation of a bathing, the skin sheet indicated the resident had no new skin concerns with no documentation of shower and the point of care history indicated no bathing occurred, and - 03/29/24, shower. The resident had 7 of 11 showers, complete bed baths, or refusals documented in the clinical health record. The current facility policy, titled "Guidelines for Bathing Preference" with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, "...Bathing shall occur at least twice a week unless resident preference states otherwise..." The current facility policy, titled "Nursing ADL [activities of daily living] Documentation Guidelines" with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, "To document the type and amount of assistance provided to the resident for activities of daily living...Completion of ADL service will be validated through the use of the CARE ASSIST ADL reports...ADL services will be conducted and documented by the CNA each shift at the [point of care] or as reasonably possible after care..."			

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	This citation relates to Complaint IN00432712. 3.1-38(a)(2)(A)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review, the facility failed to hold a resident's blood pressure medication when vitals were outside of the physician's hold parameters for 1 of 16 residents reviewed for quality of care. (Resident E) Findings include: The clinical record for Resident E was reviewed on 05/02/24 at 10:10 A.M. An Admission Minimum Data Set assessment, dated 03/06/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, anemia, diabetes, heart failure, and hypertension. A current physician's order, with a start date of 02/28/24, indicated the resident was to get metoprolol succinate (a blood pressure medication) extended release 24 hour tablet, 100 mg (milligrams), one time a day, for hypertension. The staff were to hold the medication if the resident's heart rate was less than 60.	F 0684	1. Resident E was affected. Resident E noted to not have blood pressure medication held when vitals were outside of the physician's hold parameters. Resident assessed and noted no adverse effects noted. 2. All like residents have the potential to be affected. Licensed staff educated on the Medication Administration-General Guidelines. 3. As a measure of ongoing compliance, the DHS or designee will perform medication audits of residents receiving blood pressure medication during morning clinical care meeting to ensure parameters set by physician are compliant: audits will be completed for 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3	05/30/2024

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	The March and April 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident received the medication when the heart rate was less than 60 on the following dates: - On 03/05/24, the resident's heart rate was 55. - On 03/07/24, the resident's heart rate was 57. - On 03/08/24, the resident's heart rate was 52. - On 03/09/24, the resident's heart rate was 55. - On 03/10/24, the resident's heart rate was 56. - On 03/14/24, the resident's heart rate was 51. - On 03/16/24, the resident's heart rate was 55. - On 03/24/24, the resident's heart rate was 47. - On 03/26/24, the resident's heart rate was 55. - On 04/04/24, the resident's heart rate was 45. - On 04/10/24, the resident's heart rate was 53. - On 04/17/24, the resident's heart rate was 59. - On 04/22/24, the resident's heart rate was 51. - On 04/30/24, the resident's heart rate was 49. During an interview on 05/08/24 at 2:49 P.M., Licensure Practical Nurse (LPN) 5 indicated if a resident's medication had hold parameters for the heart rate, the heart rate should be obtained prior to the medication being given. If the heart rate was outside of the parameters, the medication shouldn't be administered, and the Nurse Practitioner should be notified. The current facility policy titled, "Medication Administration-General Guidelines" with a revised date of 11/18, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, " ...Medications are administered in accordance with the written orders of the prescriber..."		months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	This citation relates to Complaint IN00433027. 3.1-40(a)(1) 3.1-40(a)(2) 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to follow a resident's diet order for 1 of 2 residents reviewed for therapeutic diets. (Resident C) Findings include: During a continuous observation and interviews on 04/29/24 from 12:16 P.M. through 12:29 P.M., the following was observed in the 600 Hall dining	F 0692	1 Resident C was affected by alleged deficient practice. Diet orders were reviewed and updated as needed. 2 All residents have the potential to be affected. Nursing staff educated on nutrition/hydration guidelines. 3 As a measure of ongoing compliance, the DHS or designee	05/30/2024

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	room: - At 12:16 P.M., Resident C was sitting at a dining room table, waiting for lunch, - At 12:20 P.M., Resident C was served a lunch plate that contained a slice of ham, cheddar hashbrowns, roasted carrots, and a piece of cake, RN 6 went and cut up the resident's ham into bite size squares. The resident's meal ticket sitting on the table in front of her indicated she was a mechanical soft diet, - At 12:25 P.M., RN 6 indicated the resident's diet orders were in the electronic record. When the resident had a new diet order it would get sent to the kitchen and printed on their meal ticket. The staff should follow the meal ticket. Resident C used to be on a mechanical soft diet, but it had recently changed but the kitchen hadn't updated her meal ticket, she confirmed the meal ticket indicated mechanical soft. She confirmed the resident order in the clinical record was started on 04/10/24 as a mechanical soft diet and indicated she should have been served a mechanical soft diet until the order changed. She would have to confirm with the Speech Therapist about the resident's diet, -At 12:27 P.M., the Speech Therapist indicated the resident was to be on a mechanical soft diet and should have been served a mechanical soft meal. She went and observed the resident and ordered a mechanical soft diet from the kitchen, -At 12:29 P.M., the Dietary Manager indicated the cook working in the 600 Hall kitchen had never worked down there before. The resident's all had meal trays that indicated what their diet was, and the kitchen and other staff should follow the diet		will perform diet audits to ensure proper nutrition/hydration documentation is in place: Audits will be conducted on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	order. The meal tickets would be updated if the order changed. The aides should be looking at the tickets when serving the meals to ensure the meal served is the correct diet. If the meal was incorrect, they would give it back to the cook to get the correct diet. The resident's diet order was reviewed on 04/29/24 at 12:25 P.M. The open ended, diet order with a start date of 04/10/24, indicated the resident was to be on a mechanical soft diet with extra gravy and no straws. An Admission MDS (Minimum Data Set) assessment, dated 04/03/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, hypertension, heart failure, diabetes, malnutrition, anxiety, and depression. The resident had episodes coughing or choking during meals or when swallowing medications and had complaints of difficulty or pain with swallowing and had no natural teeth. The resident did not have any documented concerns related to coughing or choking after the admission assessment. The current facility policy titled, "Resident Dining & Nutritional Preferences" with an approval date of January 2024, was provided by the DON (Director of Nursing) on 05/06/24 at 2:41 P.M. The policy indicated, "...The Dining Services and Clinical Nutrition Support teams have continued commitment to ensuring our residents have the best dining experience possible...The dietary order is included in the 48-hour baseline care plan...The individual resident's food plan meets his or her nutritional needs..."			

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	3.1-46(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review, and interview, the facility failed to follow physician	F 0755	1 Resident 219 was affected by alleged deficient practice.	05/30/2024

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	orders related to a blood thinner for 1 of 6 resident reviewed for pharmacy services. (Resident 219) Findings include: During an observation on 05/01/24 at 2:20 P.M. Resident 219 was lying in his bed. His call light was in reach, and he said he was feeling good that day with no concerns. The resident had no visible bruises or bleeding. The clinical record for the resident was reviewed on 05/06/24 at 12:13 P.M. An Admission MDS (Minimum Data Set) assessment, dated 04/19/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture, anemia, atrial fibrillation, and hypertension. The resident had received an anticoagulant while in the facility. A Progress Note, dated 04/24/24 at 4:01 P.M., indicated a new order was received to give Coumadin 7 mg daily and recheck the PT/INR (Prothrombin Time/International Normalized Ratio) on 04/26/24. A Progress Note, dated 04/26/24 at 12:57 P.M., indicated a new order was received to continue Coumadin 7 mg daily and recheck PT/INR on 04/29/24. A Progress Note, dated 04/29/24 at 12:55 P.M., indicated a new order was received to start Coumadin 2 mg on Sunday, Monday, Wednesday, and Friday. Give 3 mg on Tuesday, Thursday, and Saturday. A physician's order, dated 04/24/24 through 04/29/24, indicated the resident was to receive Warfarin (Coumadin), a 5 mg with the 2 mg tablet		Resident was assessed with no adverse events noted. Blood thinner medication orders were reviewed and updated as needed. 2 All like residents have the potential to be affected. Nurses educated on Medication Administration policy. All residents with blood thinner orders were reviewed for appropriate orders which were in place. 3 As a measure of ongoing compliance, the DHS or designee will review blood thinner orders to ensure proper order placement in medical record, audits will be completed on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	to equal 7 mg, once a day. A physician's order, dated 04/24/24 through 04/26/24, indicated the resident was to receive Warfarin, a 2 mg, with the 5 mg tablet to equal 7 mg, once a day. The April EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident lacked receiving the Coumadin dose 2 mg from 04/26/24 through 04/28/24. During an interview on 05/06/24 at 2:40 P.M., RN 6 indicated when a resident had orders for PT/INR's they were completed first thing in the morning. The night shift nurse would obtain the results and send them to the physician. The day shift nurse would then coordinate with the physician if the dose needed to be changed or remained the same. The nurse working the floor, or the physician could input the resident's orders. During an interview on 05/08/24 at 11:15 A.M., the DON (Director of Nursing) indicated she was unsure why the resident's 2 mg dose of Coumadin had discontinued on 04/26/24 when the order was to remain the same. The current facility policy titled, "Medication Administration-General Guidelines" with a revised date of 11/18 was provided by the DON on 05/08/24 at 9:55 A.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principals and only by persons legally authorized to do so..." 3.1-37(a)			

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SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey, and the Investigation of Complaints IN00430897, IN00431864, IN00431890, IN00432712, IN00432795, and IN00433027 Complaint IN00430897 - Federal/State deficiency related to the allegation is cited at F687. Complaint IN00431864 - Federal/State deficiency related to the allegation is cited at F687. Complaint IN00431890 - No deficiencies related to the allegation was cited. Complaint IN00432712 - Federal/State deficiency related to the allegation is cited at F677. Complaint IN00432795 - No deficiencies related to the allegations were cited. Complaint IN00433027 - Federal/State deficiency related to the allegation is cited at F684. Survey dates: April 29 and 30, May 1, 2, 3, 6, and 8, 2024 Facility number: 002955 Residential Census: 27 Silver Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on May 20, 2024.	R 0000	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 to respond to the allegations of noncompliance cited during the Complaint Survey conducted May 8, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 30, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	