STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155671	A. BUILDING 00 B. WING	07/01/2024

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

(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. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2024 Facility number: 002512 Provider number: 155671 AIM number: 200278690 Census Bed Type: SNF/NF: 59 SNF: 16 Residential: 18 Total: 93 Census Payor Type: Medicare: 12 Medicaid: 48 Other: 15 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 3, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mary C. Blocker | Executive Director | 07/17/2024

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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	tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 3 residents reviewed for receiving oxygen therapy. A resident's oxygen concentrator and portable oxygen tank were not set at the ordered Liters Per Minute (LPM). (Resident 13) Finding includes: On 6/24/24 at 10:23 A.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per nasal cannula (NC) that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 2 LPM. The tubing was not dated. There was an oxygen concentrator machine at bedside with a dusty filter. On 6/27/24 at 9:49 A.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per NC that was connected to the oxygen concentrator machine at bedside with the setting on at 1.5 LPM and the NC tubing was resting on top of the resident's nose. The filter of the oxygen concentrator machine was dusty. On 6/27/24 at 1:25 P.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per NC that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 0.5 LPM.	F 0695	1 Resident #13 was affected by the alleged deficient practice. Resident was immediately assessed with no adverse effects noted. Resident #13's oxygen concentrator was removed from the room, replaced, and flow rate adjusted to correct setting. Licensed nursing staff were immediately educated on dating oxygen tubing, cleaning the filter of the concentrator, and verifying the flow rate is set per order. 2 All like residents have the potential to be affected. Licensed staff to be educated on cleaning of filter, dating oxygen tubing, and verifying the oxygen flow rate is set per MD order. 3 As a measure of ongoing compliance, the DHS or designee will audit 5 residents for clean oxygen concentrator filter weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for proper dating of oxygen tubing weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee	07/19/2024

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	On 6/27/24 at 1:30 P.M., Registered Nurse (RN) 26 observed the resident in the bathroom with staff toileting him and the resident wearing oxygen per NC that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 0.5 LPM. The resident indicated he was not short of breath. She proceeded to take the resident's oxygen saturation and it read 91-92%. At that time, she adjusted the resident's portable oxygen tank setting to 2 LPM. On 6/27/24 at 12:21 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, and heart failure. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated Resident 13's cognition was moderately impaired, he was an extensive assist of 2 staff for bed mobility, transfers, toileting, and on oxygen. Current Physician's Orders included, but were not limited to, the following: Change oxygen tubing monthly once a day on the 1st of the month, dated 3/14/24 Clean external concentrator filter every two weeks once a day on Sunday, dated 3/14/24 Oxygen at 2 LPM per NC, continuously, three times a day, ordered 3/14/24 A current Congestive Heart Failure (CHF) Care Plan, revised 5/20/24, included, but was not limited to, the following interventions: Oxygen per MD orders, initiated 3/7/24 On 6/27/24 at 1:13 P.M., the June 2024 Treatment Administration Record (TAR) was reviewed and		will audit 5 residents for oxygen flow rate set per MD order 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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	indicated the external filter was cleaned on 6/23/24 and the resident's oxygen saturation levels ranged from 94-98% while wearing oxygen. During an interview on 6/27/24 at 1:35 P.M., RN 18 indicated the nurse was responsible for making sure the oxygen setting was as ordered and moving the residents oxygen tubing from the portable tank to the concentrator should be done by the nurse. She was not sure how long the resident had been connected to his portable oxygen tank because she observed the resident on his oxygen via the concentrator machine before lunch but had not looked at his oxygen after. At that time, she indicated his normal oxygen saturation would be in the upper 90's, like 95-97%, with his oxygen on. She indicated the oxygen setting on the oxygen concentrator machine should be checked every shift when the resident was connected to it and as needed and the portable tank should be checked when resident was first connected to it and as needed. On 6/28/24 at 11:57 A.M., a current Respiratory Care Policy and/or a Following Physician's Orders Policy was requested and the Regional Support indicated there was not a policy for following the physician's orders but it would be the policy for staff to follow orders. 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.			

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	(ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure Posted Nurse Staffing sheets contained the correct information daily for 1 of 6 days reviewed during the survey. (6/24/24) Findings include:	F 0732	1 No residents were affected by the deficient practice. Daily staffing sheet with counts was immediately posted. 2 No residents have the potential to be affected. Education to be provided to the	07/19/2024

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	On 6/24/24 at 10:39 A.M., the Posted Nurse Staffing was observed hanging on the wall across from the 100, 200, and 300 nurses' station dated 6/14/24. During an interview on 6/28/24 at 11:58 A.M., the DON (Director of Nursing) indicated that the scheduler hung the Posted Nurse Staffing first thing in the morning. The DON indicated that she had been doing it while the scheduler was out for the last few days. On 6/28/24 at 12:07 P.M., the DON provided a Guidelines for Staff Posting Policy, revised 5/11/16, which indicated "Purpose was to ensure compliance with federal regulations posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care."		leadership team on the requirements of posting the daily staffing sheet with counts. 3 As a measure of ongoing compliance, the ED or designee will verify posting of daily staffing sheet with counts 5x/weekly for 4 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.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and			

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	controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording			

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	incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents observed for a medication pass and 1 of 3 observed for incontinence care. During a med pass, pills were dropped on the medication cart and administered to a resident. Staff did not use hand hygiene between glove changes during care. (Resident 35, Resident 9) Findings include: 1. On 6/27/24 7:14 A.M., Registered Nurse (RN) 12 was observed preparing and passing medications to Resident 35. After RN 12 prepped all 16 of the resident's pills into medication cups, she put on gloves and knocked one of the medication cups over spilling out the resident's Keppra (anticonvulsant), Namenda (cognition enhancing), and docusate sodium (stool softener) onto the medication cart. RN 12 picked them up with her gloved hand, put them back into the medication cup, took the pills out of the cup that needed to be crushed and crushed them. Then she opened the pills that were capsules and dumped all the	F 0880	Residents #35 and #9 suffered no ill effects from the alleged deficient practice. RN #12 was immediately educated on infection control practices during med pass. CNA #28 was immediately educated on proper hand hygiene with incontinence care. All residents have the potential to be affected. Education to be provided to licensed clinical staff on proper hand hygiene practices during medication pass. Education to be provided to clinical staff on infection control practices with incontinence care. As a measure of ongoing compliance, the DHS or designee will observe 3 random clinical staff members for proper hand hygiene during incontinence care 5x/week x4 weeks, then 3x/weekly x4 weeks, then every other week x4 weeks, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will observe 3 random licensed	07/19/2024

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	medications together, put chocolate pudding into the cup, and administered them to the resident. During an interview on 6/27/24 at 2:38 P.M., the Infection Preventionist (IP) indicated any pills dropped onto a medication cart while preparing medications for a resident should be disposed of and the person preparing the medications should get new ones to administer to the resident. 2. During an observation on 6/27/24 at 11:16 A.M., Certified Nurse Aide (CNA) 28 assisted Resident 9 to the restroom. CNA 28 removed Resident 9's soiled brief with gloved hands, grabbed the new brief, and placed it on the resident, removed gloves, donned new gloves, and wiped stool off resident 9's bottom. At that time, CNA 28 failed to remove gloves and perform hand hygiene before Resident 9's brief was pulled up. At that time, hand washing was performed for a 5 second lather. During an interview on 6/27/24 at 2:38 P.M., the Infection Preventionist (IP) indicated staff should perform hand hygiene between glove changes. During an interview on 6/28/24 at 9:46 A.M., Registered Nurse (RN) 12 indicated staff should lather for 20 seconds when hand hygiene is performed. On 6/28/24 at 8:00 A.M., a current Medication Administration Preparation General Guidelines Policy, revised January 2018, was provided by Regional Support and indicated "Medications are administered as prescribed in accordance with good nursing principles and practices ... after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration) ... "		clinical staff members 5x/weekly x4 weeks, then 3x/weekly x4 weeks, then every other week x4 weeks, then monthly x3 months to ensure proper infection control practices are being followed with med administration. As a quality measure, the DHS or designee will review any findings and corrective action weekly in QAPI meetings until achieved compliance, then 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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	On 6/28/24 at 12:13 P.M., the Director of Nursing (DON) provided a Guideline for Handwashing/Hand Hygiene policy, revised 2/9/17 that indicated, "...Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of antiseptic hand rub, also known as alcohol-based hand rub...d. After removing gloves...Wash well for at least 20 seconds, using a rotary motion and friction..." 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2024 Facility number: 002512 Residential Census: 18 Oakwood Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements	

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			governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	