STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET 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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00439751. Complaint IN00439751 -Federal/State deficiency related to the allegation is cited at F689. Survey date: September 09, 2024. Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF: 26 SNF/NF: 25 Residential: 32 Total: 83 Census Payor Type: Medicare: 14 Medicaid: 21 Other: 16 Total: 51 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 17, 2024.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to prevent a fall during care that resulted in a fracture for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: During an observation on 09/09/24 at 2:31 P.M., Resident B was lying in bed with his call light in reach. The resident was lying on an air mattress and there were no side rails or grab bars on the bed. The resident's bed was located by the door. The resident's bathroom door was located on the far side of the room by the other resident's bed. The clinical record for the Resident was reviewed on 09/09/24 at 10:33 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/17/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, hypertension, and multiple sclerosis. The resident had impairments to the upper and lower extremities. The resident was dependent on staff assistance for all care. A Care Plan, with a start date of 10/04/21 and a revision date of 8/21/24, titled ADL (Activities of Daily Living), indicated the resident required two staff assistance with bed mobility. A Progress Note, dated 07/22/24 at 1:32 P.M., indicated after changing the resident's coccyx wound dressing at 7:30 A.M., the staff was walking around the resident's bed to assist with a	F 689	Past noncompliance: no plan of correction required.	

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full body lift sling. The resident rolled off the bed between the wall and the bed. The resident had a 7 cm (centimeter) x (by) 7 cm bruise noted to the right forearm and a 2 cm x 1 cm x 1 cm skin tear in the bruised area. First aid was applied, and new treatment orders were received from hospice. The family was notified. The resident had no complaints of pain or discomfort at that time and the resident's vital signs were within normal limits.

An IDT (Interdisciplinary Team) Progress Note, dated 07/23/24 at 10:17 A.M., indicated the resident rolled off the bed to the floor space between the wall and the bed onto the left side of the body during a dressing change. There was a bruise noted to the right arm with a skin tear. The initial intervention, on 7/22/24, was to apply first aid. A new intervention, dated 7/30/24, was initiated to have two staff assistance during dressing changes.

A Progress Note, dated 07/25/24 at 10:14 P.M., indicated the resident had discoloration and warmth noted to the right shin. The Hospice nurse was notified and was in the building to look at the resident. A new order was obtained to obtain an x-ray of the right leg.

A Progress Note, dated 07/26/24 at 5:04 P.M., indicated the resident had an x-ray at approximately 3:10 P.M. At about 3:43 P.M., the results for the x-ray were received. The resident had an acute distal tibia/fibula (lower bones of the leg) fracture. The Hospice nurse was in the facility and the resident was sent to the local emergency room for splinting of the leg.

A Progress Note, dated 07/26/24 at 8:44 P.M.,

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indicated the resident returned to the facility. The resident was non-weight bearing to the bed and the leg should be supported when moving and rotating. The resident was to follow-up with an orthopedic surgeon for casting.

A Radiology Report, dated 07/26/24 at 3:21 P.M., indicated the resident had a right ankle x-ray for pain and swelling. The results were "...Distal tibia/fibula fractures with mild displacement..."

An ED (Emergency Department) Hospital Note, dated 07/26/24, indicated the resident present to the ED with concerns for a right leg injury. The resident fell out of bed on 07/22/24. Due to changes in color of the leg an x-ray was obtained, which showed a fracture. The resident was transferred to the ED for further evaluation and splinting. The radiology report of the right tibia/fibula result indicated the resident had fractures involving the distal shafts of the tibia and fibula. The assessment/plan was for the resident to be placed in a posterior leg splint and to follow up with orthopedic for casting.

During an interview on 09/09/24 at 11:27 A.M., RN 2 indicated on 07/22/24, he and CNA (Certified Nurse Aide) 3 were in the resident's room changing a dressing to the coccyx. He had done the dressing change a thousand times. He inflated the resident's air mattress to the firm setting before the dressing change. He was on the resident's right side of the bed and CNA 3 was on the left side of the bed during the dressing change. After he finished, he was fastening the resident's brief when CNA 3 stepped away from the bed to get the resident's full body lift pad. He was walking around the end of the bed, while the resident was still lying on his left side, to go to the

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left side. As he was rounding the end of the bed the resident had rolled off the left side of the bed, "like a log." He never saw the resident move or twitch. After the fall, the resident was assessed and noted to have a skin tear and bruise to the right arm. There were no other concerns at that time and the resident was transferred to his wheelchair. A few days after the fall the resident was noted to have a fracture to his right tibia/fibula. The resident required two staff assistance while in bed and required an air mattress. He believed the resident's air mattress wasn't as stable since he had it on "firm". If the resident was turned to their side, then someone should stay on the side the resident was rolled to.

During an interview on 09/09/24 at 11:47 A.M., CNA 3 indicated she was in the resident's room with RN 2 while he was changing the dressing for Resident B. The resident was lying on his left side while the RN completed the dressing change to his bottom. She moved away from the left side of the bed to go to the resident's bathroom (located on the far side of the room) to get his full body lift pad. While she was away from the bed the resident had rolled out. The resident required one to two staff assistance while in bed. She was able to complete care on him by herself while he was in bed, but other staff needed two people to complete the care. If she was rolling a resident in bed for care she would grab the draw sheet, scoot the resident toward her, and then roll the resident away from her.

During an interview on 09/09/24 at 2:20 P.M., CNA 4 indicated if a resident was dependent on staff for all care while in bed she would take two staff in the room. There would be one person on each side. If she was providing care by herself,

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she would always roll the resident toward her and never away from her so they wouldn't fall out of bed.

During an interview on 09/09/24 at 3:02 P.M., the DON (Director of Nursing) indicated that staff were providing care for Resident B. He was lying on his left side when the CNA left the bedside to grab the resident's chair. The RN went to walk around to get the full body lift pad. The air mattress was on the firm setting and then returned to the normal setting, causing the bed to deflate a little, which caused the resident to roll out of bed. The resident had obtained a skin tear and bruise to the right arm. No other injuries were observed at that time. On 07/25/24 the resident was noted to have warmth and redness to the right leg and hospice gave orders to obtain an x-ray. On 07/26/24 the results came back and showed the resident had a tibia/fibula fracture. The resident was sent to the local emergency room and was placed in a splint. The resident followed up with the orthopedic doctor on 08/02/24 and was placed in a cast. The facility didn't have a policy for turning residents in bed. Staff were trained in CNA class to turn residents' side to side. The type of care that was being provided would determine if the resident was turned towards staff or away from staff. The fall was caused by the air mattress deflating.

During an interview on 09/09/24 at 3:45 P.M., RN 5 indicated Resident B had never had side rails or grab bars on his bed. If the resident did have them on the bed, he wouldn't have been able to grip them.

The current facility policy titled, "Fall Management Program Guidelines" with a review date of

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12/31/23 was provided by the DON on 09/09/24 at 1:37 P.M. The policy indicated, "...to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..."

The current facility policy titled, "Turning and Repositioning" with a review date of 12/31/23 was provided by the DON on 09/09/24 at 1:37 P.M. The policy indicated, "...To identify residents who are unable to turn and reposition themselves or those requiring assistance to reposition while in bed and assist with turning and repositioning as needed to maintain skin integrity, decreased pain, and maintain proper body alignment...Proper turning techniques and body mechanics should be utilized to prevent injury to the resident and care giver..."

The current "Indiana Nurse Aide Curriculum-Procedure #55: Occupied Bed" was reviewed on 09/09/24. The procedure indicated, "...The caregiver will raise the side rail on far side of bed (if rail not in use, ensure there is a second caregiver on the opposite side of the bed to ensure that the resident does not roll over the side of bed). Assist resident to turn onto side moving away from you toward raised side rail (or second caregiver)..."

The Past noncompliance began on 7/22/24. The deficient practice was corrected by 8/14/24 after the facility implemented a systemic plan that included the following actions: Nurses and aides were educated on turning a repositioning resident dependent on staff. Staff were educated on accident hazards related to air mattress, bed mobility, and falls. Return demonstration of proper rolling/turning/repositioning techniques.

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