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	11/01/2022

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 the Investigation of Complaints IN00392628 and IN00392018. Complaint IN00392628 - Unsubstantiated due to lack of evidence. Complaint IN00392018 - Substantiated. Federal/State deficiencies related to the allegations are cited at F676 and F641. Survey dates: October 31 and November 1, 2022. Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 20 SNF: 33 Residential: 28 Total: 81 Census Payor Type: Medicare: 27 Medicaid: 18 Other: 8 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 4, 2022.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Executive Director	11/11/2022

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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	resident's status. Based on record review and interview, the facility failed to accurately document a medication error in detail and the full assessment for a medication error in the resident's clinical record for 1 of 3 residents reviewed for accuracy of assessment. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/31/22 at 10:11 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, sepsis, cancer, anemia, hypertension, anxiety, depression, and respiratory failure. The resident required the extensive assistance of two physical staff for bed mobility. A Medication Error Event, dated 08/24/22, indicated the resident had received another resident's guaifenesin (cough medication) liquid. He had received the correct dose. No other information was documented. The medication event information was not completed. During an interview on 11/01/22 at 9:22 A.M., the DON (Director of Nursing) indicated RN 3 had come to her and said she had given Resident B another resident's cough medication, but it was the correct dose. The family and Nurse Practitioner were notified. The resident was assessed, and his vitals were obtained every shift for 72 hours after the event. When a medication error took place a medication error event form would be initiated, staff would notify the appropriate parties, monitor the resident for any change in condition, and monitor the resident's vital signs. Verbal education was provided to the	F 0641	**F 641 Accuracy of Assessments** It is the practice of this provider to provide care/services for highest wellbeing in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident B no longer resides at the campus **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents with medication error events will be reviewed to ensure proper documentation of the medication error occurred by November 18, 2022. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · DNS/designee will conduct in-service with all nursing staff on proper documentation/procedure for medication errors by November 18, 2022. **4: How the corrective action will be monitored to ensure the deficient practice will not recur**	11/18/2022

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	nurse on identifying the correct resident before administration of medication. She did not document that the nurse was provided verbal education. She would document a written warning on the second occurrence. The residents medication error form documentation should have been completed. During an interview on 11/01/22 at 9:53 A.M., LPN (Licensed Practical Nurse) 4 indicated she was unaware of any medication errors with residents in the building. During an interview on 11/01/22 at 9:54 A.M., RN 3 indicated when administering a resident's medications she would ensure the five rights were being followed such as, right resident, right medication, right dose, right route, and right time. The current facility policy, titled "Guidelines for Medication Error Reporting", with a review date of 10/01/21, was provided by the DON on 11/01/22 at 10:39 A.M. The policy indicated, "...To identify medications given in error and expedite correction actions...Initiate the appropriate Event form. Monitor the resident closely for 72 hours or as directed...Document the following in the resident's clinical record: a. A description of the error (brief) b. Name of physician and time notified c. Physician's subsequent orders..." This Federal tag relates to Complaint IN00392018 .		**i.e. what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of Medication Error QA tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date of completion:** November 18, 2022	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in			

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	activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on record review and interview the facility failed to provide appropriate bathing for 1 of 3 residents reviewed for ADL's (Activities of Daily Living). (Resident B) Findings include:	F 0676	**F 676 Activities Daily Living** It is the practice of this provider to provide care/services for highest wellbeing in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those**	11/18/2022

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	The clinical record for Resident B was reviewed on 10/31/22 at 10:11 A.M. The resident was admitted to the facility on 8/16/22. An Admission MDS (Minimum Data Set) assessment, dated 08/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, sepsis, cancer, anemia, hypertension, anxiety, depression, and respiratory failure. The resident required the extensive assistance of two physical staff for personal hygiene. During the seven day look back period bathing had not occurred. The Point of Care History, dated 08/16/22 through 08/28/22, indicated the resident had a partial bed bath on 08/23/22 and a complete bed bath on 08/26/22. The clinical record lacked any documentation the resident had refused any showers. During an interview on 10/31/22 at 1:21 P.M., CNA (Certified Nurse Aide) 2 indicated residents would be offered a bath twice a week. They were able to bath anytime they want to. The nursing staff encourage the residents to take showers but can give bed baths upon their request. The baths or showers would be documented in their computer charting. If the resident refused a shower or bath, she would document it in the point of care. The residents should have some sort of bath twice a week. During an interview on 11/01/22 at 9:22 A.M., the DON (Director of Nursing) indicated all residents routinely have showers twice a week. The resident could request more frequent baths if they request. The resident showers were to be documented in the care assist. If a resident refused it would also be documented in the care assist and the nurse		**residents found to have affected by the deficient practice?** · Resident B no longer resides at the campus **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents reviewed to ensure that all residents are receiving proper bathing at least twice a week or have properly documented refusals of the residents declining their bathing by November 18, 2022. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · DNS/designee will conduct in-service with all nursing staff on ensuring proper bathing occurs for all resident or proper documentation of resident's refusal of bathing by November 18, 2022. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of Resident Bathing QA tool weekly	

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	would be notified. The current facility policy, titled "Guidelines for Bathing Preference" with a review date of 12/01/21, was provided by the DON on 11/01/22 at 10:39 A.M. The policy indicated, "...Bathing shall occur at least twice a week unless resident preference states otherwise..." The current facility policy, titled "Nursing ADL Documentation Guidelines" with a review date of 12/01/21, was provided by the DON on 11/01/22 at 10:39 A.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..." This Federal tag relates to Complaint IN00392018. 3.1-38(a)(2)(A)		times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date of completion:** November 18, 2022.	