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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00403991. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00403991 - No deficiencies related to the allegations are cited.<br><br>Survey dates: March 27, 28, 29, 30, 31, April 3, 4, 2023<br><br>Facility number: 002512<br>Provider number: 155671<br>AIM number: 200278690<br><br>Census Bed Type:<br>SNF/NF: 73<br>Residential: 21<br>Total: 94<br><br>Census Payor Type:<br>Medicare: 11<br>Medicaid: 42<br>Private: 15<br>Other: 5<br>Total: 73<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 21, 2023. | 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 0605<br>SS=D<br>Bldg. 00 | 483.10(e)(1), 483.12(a)(2)<br>Right to be Free from Chemical Restraints<br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including: | | | |

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

Mary C. Blocker | Executive Director | 05/05/2023

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| | §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>Based on interview, observation, and record review, the facility failed to ensure the resident right to be free of chemical restraint for 1 of 6 residents reviewed for falls. An anti-anxiety medication (lorazepam) was used as a chemical restraint to control the resident's behaviors in an effort to keep them from falling. (Resident 47)<br><br>Findings include:<br><br>On 3/27/23 at 12:41 P.M., Resident 47 was observed sitting in a high back wheelchair in the | F 0605 | Plan of Correction:<br>Resident # 47 was affected by the alleged deficient practice.<br>Resident was assessed for increased lethargy with no findings.<br>All like residents have the potential to be affected. Licensed staff will be educated on implementing appropriate fall interventions. Licensed staff will be educated on appropriate PRN | 05/12/2023 |

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| | commons area in front of the television sleeping.<br><br>On 3/27/23 at 1:40 P.M., Resident 47 was observed laying in bed asleep.<br><br>On 3/28/23 at 9:02 A.M., Resident 47 was observed sitting in a high back wheelchair in the commons area in front of the television sleeping.<br><br>On 3/29/23 at 2:45 P.M., Resident 47 was observed laying in bed asleep.<br><br>On 3/30/23 at 10:05 A.M., Resident 47 was observed laying in bed asleep.<br><br>On 3/31/23 at 9:45 A.M., Resident 47 was observed laying in bed asleep. The resident did not arouse with knocking on the door or saying good morning in a normal tone voice.<br><br>On 3/31/23 at 11:03 A.M., Resident 47 was observed laying in the same position as earlier in bed asleep. There were 2 visitors and her roommate having a normal tone conversation and the Hospice Nurse was in the room doing vitals on the resident and having a conversation in the room while the resident slept.<br><br>On 3/31/23 at 12:41 P.M., Resident 47 was observed sitting in a high back wheelchair with her eyes closed.<br><br>On 3/31/23 at 2:15 P.M., Resident 47 was observed in bed asleep and did not arouse to verbal stimuli.<br><br>On On 3/29/23 at 12:26 P.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 1/6/21. Diagnoses included, but were not limited to, dementia with behavioral disturbance, history of falling, past CVA(cerebrovascular | | antianxiety use.<br>As a measure of ongoing compliance, the DHS or designee will complete a Health Center audit of 5 residents to ensure appropriate fall interventions in place 5x/week for 4 weeks, then 5x every other week for 2 months, then monthly for 3 months. The DHS or designee will complete a Health Center audit of 5 residents receiving PRN antianxiety medications to ensure proper interventions are in place 5x/week for 4 weeks, then 5x every other week for 2 months, then monthly for 3 months.<br>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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| | accident/stroke), and conduct disorder, unspecified.<br><br>The most recent annual MDS (Minimum Data Set) Assessment, dated 1/4/23, indicated that Resident 47's cognitive status was unable to be assessed because they were rarely able to be understood and an extensive assist of 2 (two) staff for bed mobility, transfers, and toileting. It also indicated that Resident 47 was on hospice and the following behaviors were observed in the 7 day look back period:<br>Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)-Behavior of that type occurred 1 to 3 days.<br><br>Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)-Behavior not exhibited.<br><br>Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)-Behavior of that type occurred 4 to 6 days, but less than daily.<br><br>Did any of the identified symptom(s) put the resident at significant risk for physical illness or injury, significantly interfere with the resident 's care, significantly interfere with the resident 's participation in activities or social interactions, put others at significant risk for physical injury, significantly intrude on the privacy or activity of others, significantly disrupt care or living environment-all answered no.<br><br>Did the resident reject evaluation or care (e.g., | | | |

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| | bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident ' s goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals-Behavior of that type occurred 4 to 6 days, but less than daily.<br><br>How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)-Same.<br><br>Current physician's orders included, but were not limited to, the following:<br>lorazepam intensol 2 mg(milligram)/ml(milliliter) 0.5 ml orally for restlessness/anxiety per hospice three times a day, ordered on 10/31/22 and discontinued 3/28/23.<br><br>lorazepam intensol 2 mg/ml 1ml orally for restlessness/anxiety per hospice three times a day, ordered on 3/28/23.<br><br>lorazepam intensol 2 mg/ml 0.5 ml orally PRN (as needed) every 30 minutes for anxiety/terminal restlessness; receiving hospice services and medication should continue until end of life, ordered 4/11/22.<br><br>(hospice name) to treat for terminal diagnosis of Alzheimer's dementia, ordered 12/15/22.<br><br>A current risk for falls care plan, dated 1/7/21, included, but was not limited to, the following interventions:<br>ask hospice nurse to evaluate need for routine ativan r/t afternoon restlessness, initiated 7/27/22.<br><br>A current hospice care plan, dated 2/28/22, | | | |

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| | included, but was not limited to the following interventions all initiated on 2/28/22:<br>Administer drugs as needed for palliation per md order and administer pain medication as ordered and as needed<br><br>A current conduct disorder care plan, dated 1/13/21, included, but was not limited to, the following interventions all initiated on 1/13/21:<br>Assess for unmet needs such as need for toileting, rest, food, companionship, etc, determine cause for inappropriate behavior and refer to physician as needed for intervention, encourage participation in structured activities as appropriate, observe for triggers of inappropriate behaviors and alter environment as needed.<br><br>A current activities care plan, dated 10/5/22, included, but was not limited to, the following interventions all initiated on 1/4/23:<br>Introduce me to other residents who also enjoy socializing, please invite and assist me as needed to activities of my interest, such as spending time outdoors when the weather is warm enough and opportunities to socialize, I am of the Methodist faith, please provide appropriate cueing if you see that I am restless, I enjoy watching westerns such as Gunsmoke and Bonanza and also watching TV Land programs, I like to look through magazines and have a snack while doing so, listening to gospel music is one of my favorite genres.<br><br>A current behaviors care plan, dated 7/28/22, included, but was not limited to, the following interventions all initiated on 7/28/22:<br>Observe mood, affect and behaviors with all hands on care and contacts, re-direct me during periods of frustration and anger, refer to psych services as needed. | | | |

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| | A current psychotropic (lorazepam) drug care plan, dated 11/16/21, included but was not limited to, the following interventions all initiated on 11/16/21:<br>Attempt GDR (gradual dose reduction) in two separate quarters (with at least one month between the attempts)during the first year the resident receives an anxiolytic (lorazepam) medication then yearly after unless contraindicated, attempt non-pharmacological interventions prior to administering PRN anxiolytic, and observe for drug effectiveness and adverse consequences.<br><br>A review of Resident 47's progress notes included, but were not limited to, the following:<br>4/8/22 1:55 P.M.-"Resident has been having more frequent episodes of restlessness the past few days. Has frequently been attempting to stand up out of w/c and get out of bed and cannot remember that she can no longer walk. Res [resident] is requiring frequent redirection and repositioning d/t scooting to the edge of w/c seat. Res [resident] is usually easily redirected and not mean or agitated, just very restless and unable to voice why she is trying to stand. Staff will provide toileting, offer food/drinks and ask if she is pain. After ruling all needs out resident remains restless. Hospice nurse [name of nurse] here for a visit and voiced that comfort meds for terminal restlessness would be appropriate at this time and asked this nurse to notify [name of doctor]."<br><br>4/8/22 3:25 P.M.-New orders per [doctor name]: Ativan (lorazepam) Intensol 2mg/mL give 0.5 mL q30 (every 30) minutes PRN for anxiety.<br><br>4/11/22 9:08 A.M.-"IDT [interdisciplinary team] reviewed current mental health, pain, and infection events. Resident receiving hospice services and | | | |

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| | hospice pain/anxiety medications started due to resident's declining condition ... No adverse effects noted from any medications ... "<br><br>4/11/22 3:12 P.M.- "MD [medical doctor] responded to [pharmacy name] rec [recommendations] regarding rationale for Lorazepam. MD wanting res [resident] to continue on PRN med due to having episodes of anxiety. Will place new 14 day stop date at this time."<br><br>4/22/22 12:02 P.M.-"The past few days when res [resident] is up in w/c [wheelchair] is constantly scooting self to edge of seat and several has [sic] almost scooted all the way off of seat. Has dycem on top and bottom of cushion but it is not preventing it. Res [resident] appears to be uncomfortable in the chair not matter how positioned and has lost quite a bit of trunk control d/t [due to] decline in condition. Call placed to hospice nurse [nurse name] and left voicemail requesting [specific name] chair for res [resident] comfort."<br><br>6/14/22 1:30 P.M.-"Res [resident] yelling out for spouse after lunch. Reassured spouse was okay and in the building. Res [resident] accepting of this."<br><br>7/14/22 1:05 P.M.-"Attempted to give prn ativan intensol d/t restlessness and agitation but res [resident] spit it out."<br><br>7/24/22 8:00 P.M.-"Earlier today after lunch [resident] was yelling trying to out of her chair. interventions didn't help. assist to bed check and changed yelled whole time. tried giving her lorazepam she took it then spit it out this was before laying her down. she layed about 10 minutes still yelling trying to climb out of the bed | | | |

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| | but refuses to set in reclining w/c. staff administer morphine and she held it in mouth a few seconds then spit it out. continue to do the same been long enough and rn staff administer lorazepam and she didn't spit it out and she calmed down went out for supper been in her recliner w/c watching tv. going to bed now due to falling asleep in chair."<br><br>7/27/22 12:51 P.M.-"Resident yelling out help. Unable to redirect. PRN ativan given at this time."<br><br>7/27/22 03:00 P.M. "Resident observed on floor by CRCA [CNA]. Resident was sitting upright against her bed. Resident is alert and asking for staff to put her back to bed. VS 127/74, 80, 97%RA, 18, 97.9F. Moves all extremities without difficulty or pain at this time. No injuries noted. Resident assisted back to bed by staff. ADHS notified and resident to be engaged in activities during afternoon hours as an intervention. POA notified. MD notified."<br><br>7/28/22 3:53 P.M.-"Reviewed current fall event. Resident was observed on floor by nursing staff at bedside. Resident has developed tendency to become by restless [sic] in the afternoon . Resident was offered PRN medication for anxiety [lorazepam], but spit this out, so staff attempted to lay resident down to nap. Root cause analysis determined that afternoon restless [sic] led resident to attempt to get up on her own, and fall from bed (root cause.) No injuries obtained as result of fall. Denies pain or discomfort. Neuro [neurological] status and ROM [range of motion] remain within normal limits. Coordinating care with [hospice name] nurse. Spoke with hospice nurse and she will be contacting MD for possible medication changes to address afternoon restlessness/anxiety (intervention.) Plan of care and profile up to date with safety interventions." | | | |

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| | 7/29/22 10:34 A.M.-"Received a new order from hospice to make Ativan [lorazepam] routine. New dose is Ativan [lorazepam] 0.5 ml po [orally] every 8 hours and keep the prn dose the same."<br><br>8/2/22 9:19 A.M.-"IDT reviewed current mental health event. Resident noted with increased s/s of agitation and restlessness. Non-pharmacologic interventions including providing calm environment, offering rest periods, offering food and fluids, and offering activities have been ineffective. Restlessness has resulted in resident to have fall without injury from her bed. Care coordinated with [hospice name], and new orders received for routine Ativan [lorazepam] to managed [sic] s/s [signs/symptoms] of terminal restlessness. No s/s of adverse reactions to change in medication."<br><br>8/10/22 1:02 P.M.-"Resident continues to be monitored r/t [related to] fall. Resident continues with hospice services for terminal diagnosis of Alzheimer's dementia. Resident continues to have episodes of restlessness but has been better controlled with medication regimen for comfort. Resident continues with 1:1 services from activities and receives visits from Chaplain. Resident also has a volunteer that visits. Fall interventions continue to be in place and remain appropriate. Will continue with current orders and update POC as needed."<br><br>8/25/22 11:06 A.M.-"Resident being monitored f/t [sic] fall. Resident has not made any attempts to transfer self without assistance. Resident is unable to propel self in wheelchair and requires staff assistance for transfers and mobility. Staff assisted with complete care. Resident does continue with hospice services for terminal | | | |

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| | diagnosis. Will review fall interventions and update as needed."<br><br>9/18/22 2:45 P.M.-"Resident refusing medications and spitting this shift. Becomes combative when staff attempt to assist resident. Grabbed this nurse's hand and began twisting fingers stating "I'm going to break your fingers to the bone!" Resident left sitting safely in [chair name] chair near nurses station to calm down."<br><br>10/12/22 3:38 P.M.-"Received [doctor name] response in regards to eval [evaluation] of Lorazepam use from [pharmacy name] recommendation.'No!!! She is dying.Stop with the GDR requests on hospice patients.I will never say yes.Pharmacy is wasting everyone's time with this.' "<br><br>10/25/22 10:59 A.M.-"Care conference held with resident husband, [resident in facility].no concerns voiced other than wished wife didn't sleep so much."<br><br>11/25/22 1:51 P.M.-"This writer called to resident room ... Resident found sitting on [the floor on] side of bed with feet stretched out towards bathroom. Soiled linen under resident on floor. Resident unable to state how she fell. Staff assisted resident to bed at 1:15 pm and provided incontinent care. No injuries reported or observed. Call light within reach."<br><br>11/26/22 5:55 P.M.-"Res [resident] restless this shift calling out for spouse frequently. PRN roxanol and ativan intensol given for restlessness and anxiety."<br><br>11/26/22 10:51 P.M.-"IDT reviewed current fall. Prior to fall resident was lying in bed, with call | | | |

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| | light in reach. Resident was found on floor next to bed with linens underneath her. Resident had recently been laid down, and incontinence care provided. Resident does have periods of terminal restless d/t [due to] terminal disease process and receives routine antianxiety [lorazepam] for this, and available PRN as well. Staff will provide smaller blanket for use in bed (intervention.) Plan of care updated."<br><br>11/30/22 2:00 P.M.-"Called to room to find resident on floor with pillow under head.CNA (Certified Nurse Aide) had said resident was just asleep prior to passing room a few minutes to this incident.CNA assisted resident to floor from being half way to floor from bed."<br><br>11/30/22 2:49 P.M.-"Discussed with management interventions for recent fall.Will do medication review."<br><br>12/2/22 11:04 A.M.-"Resident did have recent fall on 11/30. Resident was laying in bed after noon meal for rest. Staff observed resident attempting to transfer out of bed and reported restlessness. Per staff, resident typically gets restless around 2pm daily. Staff were attempting to assist resident with getting up into chair when she did not stand completely causing staff to need to lower her to the floor (root cause). She continues to deny pain/discomfort. Resident does receiving [sic] routine ativan to help control restlessness and agitation. Time frame reviewed and adjusted to better meet resident's need (intervention)."<br><br>12/6/22 8:40 P.M.-"Res [resident] anxious yelling out restlessness attempting to climb out of bed. Res [resident] given prn Lorazepam 0.5ml 1mg per orders will continue to monitor." | | | |

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| | 12/8/22 1:44 P.M.-"Resident remains free from s/s of injury. Change of medication administration times with last fall do appear to have decreased displays of restlessness, and calling out."<br><br>12/23/22 10:57 A.M.-"Resident continues to be monitored r/t falls. Resident continues with hospice services and is occasionally restless. Resident does receive routine and PRN medications to assist with restlessness. Staff continue to offer and assist with all needs as they arise and continue to anticipate needs."<br><br>1/5/23 12:50 A.M.-"Awake, trying to climb out of bed. 1:1 time spent with resident. Incont [incontinence] care given with protective cream to buttocks. Repositioned for comfort. HOB up <30degrees. Did offer and was accepted Pink Lemonade with Comfort meds. Continue to monitor thru shift for safety."<br><br>1/22/23 3:05 P.M.-"Resident was resting in bed just prior to fall. Resident noted to be lying on her back next to her bed with her blankets underneath her body and head. Resident known to become restless at times in the afternoon while resting and unable to understand use of call light for assistance. Resident then assisted to wheelchair and taken to common area near nurses station and attempted to engage in activities."<br><br>1/25/23 3:00 P.M.-"Resident noted to be sitting on the floor leaning against the side of her bed. She states she "I want to get out of here" When asked what she was trying to do at time of fall, resident responded "Trying to get up". resident was assisted to TV room per her request."<br><br>2/5/23 4:36 P.M.-"IDT reviewed fall event. Resident was restlessness [sic] and rolled out of | | | |

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| | her bed onto the floor. (root cause) Immediate intervention: resident was assessed with comfort med given, she was assisted back to bed and bed was placed in lowest position in attempt to prevent injury."<br><br>2/5/23 4:43 P.M.-"IDT NOTE: Resident noted to be sitting on the floor leaning against the side of her bed. She states she "I want to get out of here" When asked what she was trying to do at time of fall, resident responded "Trying to get up and fell off the bed". Immediate intervention: resident was assisted to TV room per her request."<br><br>3/12/23 4:35 P.M.-"This nurse called to restorative dining room. CNA found resident perpendicular to reclining WC [wheelchair] on the floor. Unwitnessed."<br><br>3/13/23 10:34 A.M.-"IDT reviewed fall event. Resident attempted to self transfer from her wheelchair to standing position and lost balance and fell. (root cause) Resident was unable to tell staff where or what she was planning on doing."<br><br>3/16/23 9:43 A.M.-"Plan of care reviewed and continues to be appropriate for this resident. She continues with hospice services for end of life services. She does usually refuse to participate in group activities however does enjoy 1:1 visits with staff. She does continue to be high risk for falls and staff do frequent rounding in attempt to anticipate resident needs."<br><br>3/23/23 12:43 P.M.-"Resident with much anxiety and agitation, yelling out et [and] attempting to get out of chair. Attempts made by several staff to calm resident down. Resident was changed et [and] new brief placed, taken to lunch but did not eat very much. One on one, talking about | | | |

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| | memories et [and] resident would calm when someone was one on one with her but would then resume screaming as soon as someone left. Resident spit out Ativan et [and] Morphine when given even though she was yelling that her back hurt. Unsure if any medication was ingested."<br><br>3/25/23 7:36 A.M.-"Attempted to give morning medications (routine ativan prescribed to help prevent behaviors) resident was awake and sitting in her [chair name] chair. She was not receptive to taking even a sip of water. she grabbed the straw and cup and jerked it out of this nurses hand and threw it on the floor. Will reattempt at a later time."<br><br>3/25/23 9:40 A.M.-"Plan of care reviewed and continues to be appropriate for this resident. She continues with hospice services for end of life services. She does usually refuse to participate in group activities however does enjoy 1:1 visits with staff. She does continue to be high risk for falls and staff do frequent rounding in attempt to anticipate resident needs."<br><br>3/28/23 11:34 A.M.-"N/O [new order] received per hospice to increase Lorazepam to 1mL TID [three times daily] routine for increased anxiety."<br><br>Review of the January 2023 TAR (treatment administration record) indicated Resident 47 received lorazepam intensol 2mg/ml 0.5ml orally routinely three times a day from 1/1/23 through 1/31/23. The January 2023 TAR also indicated that Resident 47 received lorazepam intensol 2mg/ml 0.5 ml orally every 30 minutes PRN on the following dates:<br>1/1/23 at 11:01P.M. restlessness<br>1/5/23 at 12:56 A.M. end of life care, confusion, attempting to climb out of bed<br>1/8/23 at 7:58 P.M. attempting to climb out of bed, | | | |

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| | redirected by staff multiple times<br>1/9/23 at 5:45 P.M for yelling<br>1/14/23 at 9:16 A.M. for behavior issue (not specified)<br>1/17/23 at 8:38 P.M. for restlessness<br>1/19/23 at 11:06 P.M. for restlessness<br>1/30/23 at 10:50 P.M. for restlessness<br>1/31/23 9:46 P.M. for hollering out<br><br>Review of the February 2023 TAR indicated Resident 47 received lorazepam intensol 2mg/ml 0.5ml orally routinely three times a day from 2/1/23 through 2/28/23. The February 2023 TAR also indicated that Resident 47 received lorazepam intensol 2mg/ml 0.5 ml orally every 30 minutes PRN on the following dates:<br>2/4/23 at 9:15 P.M. for restlessness<br>2/7/23 at 4:29 P.M. for behavior issue (not specified)<br>2/25/23 at 4:21 P.M. for restlessness, anxiety<br>2/27/23 at 4:17 P.M. for behavior issue (not specified)<br><br>Review of the March 2023 TAR indicated Resident 47 received lorazepam intensol 2mg/ml 0.5ml orally routinely three times a day from 3/1/23 through morning dose on 3/28/23. From 3/28/23 noon dose through 3/31/23, Resident 47 received lorazepam intensol 2mg/ml 1 ml orally three times a day. The March 2023 TAR also indicated that Resident 47 received lorazepam intensol 2mg/ml 0.5 ml orally every 30 minutes PRN on the following dates:<br>3/5/23 at 5:47 P.M. for anxiety<br>3/5/23 at 9:59 P.M. for restlessness<br>3/16/23 at 3:45 P.M. for restlessness<br>3/20/23 at 9:46 A.M. for behavior issue (not specified)<br>3/23/23 at 12:42 P.M. for behavior issue (not specified) | | | |

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| | 3/26/23 at 5:42 P.M. for restlessness<br>3/30/23 at 11:36 P.M. for restlessness<br><br>Review of the hospice note, dated 3/31/23, indicated per the Edmonton Symptom Assessment system, Resident 47's drowsiness score (0-10) was 7 and goal for drowsiness score was 4.<br><br>During an interview on 3/30/23 at 2:50 P.M., the DON (Director of Nursing) indicated Resident 47 has not been seen by mental health professional because she is on hospice.<br><br>During an interview on 3/31/23 at 11:03 P.M. the Hospice Nurse indicated that they "recently increased ativan because she has been combative and restless. She further indicated that she [Resident 47] has fallen a lot because she gets restless and falls." The resident stayed asleep the entire interview with the hospice nurse using normal tone voice and the resident's roommate and 2 visitors talking in normal tone voices.<br><br>A current chemical restraints policy, dated 5/11/16, was provided by the DON on 4/4/23 at 10:49 and indicated " ... 5. Chemical restraints should not be used to limit or control resident behavior for the convenience of the staff or as a substitute for individualized care ... 12. Nursing services, social series and other members of the interdisciplinary team will address the behaviors in progress notes, care plans, or other forms in electronic health record. a. Medication use is not the sole approach for behavioral intervention. b. Other interventions will be identified in the care plan ... "<br><br>3.1-3(w) | | | |

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| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review, the facility failed to ensure a person-centered care plan was in place or revised to meet the resident's needs for 3 of 3 residents reviewed for developmentally disabled individuals. (Resident 39, Resident 34, Resident 3)<br><br>Findings include: | F 0657 | Plan of Correction:<br>1. Residents #3, #34, and #39 were affected by the alleged deficient practice. Residents were assessed with no adverse effects noted. Residents' care plans have been revised to reflect person-centered and individualized. | 05/12/2023 |

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| | During record reviews on 4/4/23 from 10:00 A.M. to 12:30 P.M., 3 of 3 residents reviewed for intellectual disabilities/developmental delays (ID/DD) lacked a person-centered care plan that addressed their individual needs related to their diagnosis of ID/DD.<br><br>1. Resident 39's clinical record was reviewed and included, but was not limited to, a history of spinal meningitis which led to a developmental disability. Resident 39 was admitted to the facility on 4/19/19.<br><br>A current "social aspects" care plan, dated 4/19/19, indicated a diagnosis of developmental disability related to a history of spinal meningitis. All interventions were dated 5/29/19, and included the following: encourage resident to actively participate in activities of daily living daily, care planning, and intellectually appropriate leisure and structured activity, monitor for cognitive changes with cognition level quarterly and as needed as well as monitor mood, affect, and behaviors, provide routine in daily schedule, and to receive services from the DD Board per habilitation plan.<br><br>On 4/4/23 at 1:00 P.M., a handwritten individual habilitation plan flow sheet was provided, dated for the month of February (no year). The Administrator indicated at that time the form was what the Social Services Director (SSD) had filled out for Resident 39 this past February, and had kept inside a binder in her office. The form included the following training step approaches for Resident 39: verbal cues and encouragement for self ambulation, physical prompts or gestures to dining room, and reinforcing support, encouragement, and positive ambulation. The form further indicated Resident 39 would use | | 2. All residents with intellectual disability/developmental disability have the potential to be affected. Social Service Director and MDS Coordinator educated on developing and revising individualized care plans.<br>3. As a measure of ongoing compliance, the SSD or designee will audit newly admitted residents with intellectual/developmental disability during morning clinical care meeting to ensure care plans for individual needs weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months.<br>4. As a quality measure, the SSD 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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| | wheelchair independently one time a week to the dining room for the next 90 days. The information on the form was not used to update Resident 39's care plan for all staff to have access to.<br><br>2. Resident 34's clinical record was reviewed and included, but was not limited to, a diagnosis of Cerebral Palsy. Resident 34 was admitted to the facility on 7/30/21.<br><br>A current "social aspects" care plan, dated 3/7/22, indicated a diagnosis of intellectual disability and Cerebral Palsy. All interventions were dated 3/7/22, and included the following: complete evaluations for therapy (speech, occupational, physical), encourage family involvement in care and resident's participation in facility activities as appropriate to prevent isolation and promote wellbeing, provide discharge planning to explore community living, ongoing mental health case management to ensure proper treatment and medication effectiveness, supportive counseling to help resident through hard moments and support wellbeing, refer for individual or group therapy as needed, and refer for neurological evaluation.<br><br>On 4/4/23 at 1:00 P.M., a handwritten individual habilitation plan flow sheet was provided, dated for the month of February (no year). The Administrator indicated at that time the form was what the SSD had filled out for Resident 34 this past February, and had kept inside a binder in her office. The form included the following training step approaches for Resident 34: have clothes laid out the night prior for visual care, staff to get towels and toiletries for shower and provide to resident, and give positive support and affirmations regarding tasks. The form further indicated Resident 34 would shower and dress | | | |

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| | self independently two times a week for 90 days without verbal prompts. The information on the form was not used to update Resident 34's care plan for all staff to have access to.<br><br>3. Resident 3's clinical record was reviewed and included, but was not limited to, a diagnosis of anxiety, obsessive compulsive disorder (OCD), and epilepsy. Resident 3 was admitted to the facility on 12/21/20.<br><br>A current "social aspects" care plan, dated 12/23/20, indicated a diagnosis of severe intellectual disability and epilepsy, OCD, anxiety, and other unspecified mental disorders due to known physiological condition. All interventions were dated 12/23/20, and included the following: encourage family involvement in care, resident's participation in facility activities as appropriate to prevent isolation and promote wellbeing, provide discharge planning to explore community living, ongoing mental health case management to ensure proper treatment and medication effectiveness, supportive counseling to help resident through hard moments and support well being, refer for individual or group therapy, neurological evaluation as needed, and outpatient mental health services.<br><br>On 4/4/23 at 1:00 P.M., a handwritten individual habilitation plan flow sheet was provided, dated for the month of February (no year). The Administrator indicated at that time the form was what the SSD had filled out for Resident 3 this past February, and had kept inside a binder in her office. The form included the following training step approaches for Resident 3: encourage resident to get up out of bed and sit in a chair, invite and encourage resident to activities and gatherings, and support and encourage with | | | |

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| | positive affirmations. The form further indicated that Resident 3 would utilize wheelchair twice a week for social interaction outside of room for the next 90 days. The information on the form was not used to update Resident 3's care plan for all staff to have access to.<br><br>During an interview on 4/4/23 at 1:10 P.M., the Director of Nursing (DON) indicated when selecting a care plan, staff would select a general care plan with already populated interventions. After selecting the care plan for the resident, staff should go into each intervention and make it resident specific. The DON further indicated revisions should have been made to care plans and interventions quarterly and updated as needed.<br><br>On 4/4/23 at 1:15 P.M., a current comprehensive care plan guideline policy, dated 5/22/28, was provided and indicated "Problem areas should identify the relative concerns ... Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths ... revised to reflect changes in the resident's condition as they occur"<br><br>7-4(a) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals | | | |

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| | §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation and interview, the facility failed to provide proper storage of medications in 1 of 2 medication storage rooms, 1 of 1 IV (intravenous) storage cart, and 1 of 6 medication carts. Loose pills were found in the bottom of the medication cart drawers. Expired IV fluid bags were stored in the IV treatment cart located within the storage room. (100 Hall and 600 Hall)<br><br>Findings include:<br><br>1. On 3/29/23 at 9:35 A.M., the IV storage cart located in the 600 Hall storage room was observed with the following expired bags inside:<br><br>1 (one) 1000 cc (cubic centimeter) fluid bag of Dextrose 5 percent with expiration date of August 2022<br>1 (one) 1000 cc fluid bag of Dextrose 5 percent with Normal Saline 0.9% with expiration date of January 2023<br>1 (one) 1000 cc fluid bag of Dextrose 5 percent | F 0761 | Plan of Correction:<br>1. No residents were affected by the alleged deficient practice. The 100-hall medication cart has been cleaned of loose pills. All expired IV bags have been discarded from the 600-hall storage cart. Licensed nursing staff were immediately educated on discarding loose pills from the med cart and checking for expired IV bags.<br>2. All residents have the potential to be affected. Licensed nursing staff to be educated on ensuring loose pills are removed from the drawers of the medication carts. Licensed nursing staff educated on checking storage cart for expired IV bags. Weekly schedule of IV storage cart implemented.<br>3. As a measure of ongoing compliance, the DHS or designee | 05/12/2023 |

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| | 155671 | A. BUILDING 00<br>B. WING | 04/04/2023 |

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

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| | with Normal Saline 0.2% with expiration date of February 2023<br>2 (two) 100 cc fluid bags of Dextrose 5 percent with an expiration date of August 2022<br><br>During an interview on 3/29/23 at 9:35 A.M., LPN (Licensed Practical Nurse) 8 indicated the night shift nursing staff should check the IV cart and reorder supplies.<br><br>2. On 3/29/23 at 12:27 P.M., 1 of 2 medications carts for the 100 Hall was observed in medication storage room with the following medications laying loose in the bottom of 2 drawers:<br><br>1 medium white round pill<br>1/2 (half) medium oblong purple pill<br>1 small round orange pill<br><br>On 4/4/23 at 8:30 A.M., the same medication cart was observed in the medication storage room on the 100 Hall with the following medications loose in the bottom of 2 drawers:<br><br>1 small round orange pill<br>1 large white pill<br>1 small white pill<br><br>During an interview on 4/4/23 at 8:45 A.M., QMA (Qualified Medication Aide) 12 indicated loose medications should be removed from drawers and disposed of using a a bottle of liquid drug disposal after notification of the DON ( Director of Nursing).<br><br>During on interview on 4/4/23 at 8:49 A.M., DON (Director of Nursing) indicated the pharmacist would check the IV fluid bags once a month when she visits and the night shift nursing staff should check the IV cart once a week. | | will audit 5 random medication carts for loose pills weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit the IV storage cart for expired bags weekly x4 weeks, then every other week x2 months, then monthly x3 months.<br>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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| | A current Medication Storage in the Facility policy, revised November, 2018 was provided by DON on 11:23 A.M., indicated " Medications and biological's are stored safely, securely, and properly... The medication supply is accessible only to licenses facility personnel, pharmacy personnel, or facility personnel lawfully authorized to administer medication...Policy H... Outdated, contaminated,.. medications...without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal...Expiration Dating...C. Certain medications ... such as IV solutions... require an expiration date... to insure medication and purity...."<br><br>3.1-25(m) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey, and the Investigation of Complaint IN00403991.<br><br>Complaint IN00403991 - No deficiencies related to the allegations are cited.<br><br>Survey dates: March 27, 28, 29, 30, 31, April 3, 4, 2023<br><br>Facility number: 002512<br><br>Residential Census: 21<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5. | 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 | |

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| | | | 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. | |
| R 0302<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(6)<br>Pharmaceutical Services - Deficiency<br>(6) Over-the-counter medications must be identified with the following:<br>(A) Resident name.<br>(B) Physician name.<br>(C) Expiration date.<br>(D) Name of drug.<br>(E) Strength.<br>Based on observation and interview, the facility failed to ensure the proper storage of medications in 1 of 1 medication storage rooms and 1 of 2 medication carts. Unlabeled over the counter medications were stored in a drawer in the medication storage room. An unlabeled pill was found in a medication cup in the medication cart. (Medication Cart Assisted Living, Medication Storage Room Assisted Living)<br><br>Findings include:<br><br>On 4/4/23 at 6:50 A.M., medication cart 1 of 2 medication carts on the Assisted Living Hall was observed to have 1(one) small, round pill in an unlabeled medication cup in a drawer.<br><br>On 4/4/23 at 7:15 A.M., a "community drawer" of opened, unlabeled OTC (Over the Counter) supplies were observed in the medication storage | R 0302 | Plan of Correction:<br>1. No residents were affected by the alleged deficient practice. The unlabeled pill in medication cup was immediately discarded. The unlabeled over the counter medications were immediately discarded. Licensed nursing staff were immediately educated on proper medication storage.<br>2. All residents have the potential to be affected. Licensed nursing staff educated on labeling and proper storage of medications.<br>3. As a measure of ongoing compliance, the DHS or designee will audit 2 med carts for unlabeled pills 5 times weekly x4, then every other week x2 months, then monthly x3 months. The DHS or | 05/12/2023 |

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| | room on the Assisted Living Hall that included the following:<br><br>1(one) opened, unlabeled jar Biofreeze (topical pain)<br>1(one) opened, unlabeled jar Eucerin (dry skin)<br>1(one) opened, unlabeled bottle of personal cleanser<br>1(one) opened, unlabeled bottle of anti-fungal powder<br>1(one) opened, unlabeled tube of anti-fungal cream<br>1(one) opened, unlabeled bottle of Anasep wound cleaner<br><br>During an interview on 4/4/23 at 7:00 A.M., LPN (Licensed Piratical Nurse) 4 indicated loose medications were to be immediately reported to the DON (Director of Nursing) and disposed of.<br><br>During an interview on 4/4/23 at 8:54 A.M., the DON indicated there should not be any "community or house" medications. She indicated if the facility supplied cream such as a barrier cream, to be used by a resident, the cream would be placed in a zip lock bag with the resident's name and room number on it. The expiration date on the tube would be used utilized for expiration notification.<br><br>A current Medication Storage in the Facility policy, revised November, 2018 was provided at 11:23 A.M. by DON, indicated " Medications and biological's are stored safely, securely, and properly...Policy... F. Medications labeled for individual residents are stored separately from stock medications when not in the medication cart... Expiration Dating...B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date" | | designee will audit the assisted living medication storage room for unlabeled over the counter medications 5x/weekly x4 weeks, 3x/weekly every other week x2 months, then monthly x3 months.<br>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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