| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155759 | A. BUILDING 00<br>B. WING | 06/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| GLEN OAKS HEALTH CAMPUS | 601 W CR 200 S<br>NEW CASTLE, IN 47362 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00409075. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00409075-No deficiencies related to the complaint are cited.<br><br>Survey dates: June 8, 9, 12, 13, 14, 15, and 16, 2023<br><br>Facility number: 011187<br>Provider number: 155759<br>AIM number: 200838150<br><br>Census Bed Type:<br>SNF/NF: 34<br>SNF: 15<br>Residential: 22<br>Total: 71<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 33<br>Other: 6<br>Total: 49<br><br>These deficiencies/deficiency reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 20, 2023 | F 0000 | Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the annual survey conducted on June 16, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of July 7, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance | |
| F 0557<br>SS=D<br>Bldg. 00 | 483.10(e)(2)<br>Respect, Dignity/Right to have Prsnl Property<br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amie Groce | RN | 07/03/2023 |

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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| | respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. | | | |
| | Based on observation, interview and record review the facility failed to provide a dignity bag to cover catheters for 2 of 4 reviewed for catheters (Resident 30 and Resident 50).<br><br>Findings include:<br><br>1.) During an observation on 6/08/23 at 4:26 p.m., Resident 30 was laying in bed. The resident had a catheter with no dignity bag covering.<br><br>During an observation on 6/12/23 at 1:11 p.m., Resident 30 laying in bed with no dignity bag covering the catheter.<br><br>Review of the record of Resident 30 on 6/14/23 at 2:40 p.m., indicated the resident's diagnoses included, but were not limited to, acute respiratory disease, diabetes, depression, bipolar disorder, urinary retention and history of urinary tract infection.<br><br>The plan of care for Resident 30, dated 6/23/21, indicated the resident used a Foley catheter. The interventions included, but were not limited to, maintain closed system with urinary bag below the resident's bladder and cover.<br><br>The physician order for Resident 30, dated 6/9/23, indicated the resident was ordered to have indwelling Foley catheter for obstructive uropathy and reflux uropathy. | F 0557 | Residents 30 and 50 have dignity bags in place. Residents with foley catheters have the potential to be affected. DHS or designee will complete an audit of in-house residents with foley catheters in place to ensure they have dignity bags in place. Nursing staff will be educated on the policy of preserving dignity with an indwelling catheter. As a measure of ongoing compliance DHS or designee will audit residents with foley catheters to ensure dignity bags are in place. DHS or designee will audit 5 residents with catheters 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at | 07/07/2023 |

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| | 2.) During an observation on 6/13/23 at 11:05 a.m., Resident 50 in therapy gym with no dignity bag covering her Foley catheter.<br><br>Review of the record of record of Resident 50 on 6/13/23 at 12:20 p.m., indicated the resident's diagnoses included, but were not limited to, urinary tract infection, cerebrovascular disease, non inflammatory disorder of the vagina, dehydration, non inflammatory disorder of the vulva, urinary retention, acute kidney failure and hypertension.<br><br>The plan of care for Resident 50, dated 5/18/23, indicated the resident uses a Foley catheter for a diagnoses of vaginal cyst, labial adhesions and adnexal cyst. The interventions included, but were not limited to, cover urinary bag.<br><br>The physician order for Resident 50, dated 6/9/23, indicated the resident was to have a Foley catheter for vaginal cyst impeding bladder.<br><br>During an interview with the Director of Health Services on 6/13/23 at 11:55 a.m., indicated the CNA's and nurses were responsible to ensure residents with catheters had dignity bags covering the catheter.<br><br>During an interview with the Executive Director on 6/14/23 at 11:17 a.m.,indicated the facilities expectation was that dignity bags would be used for residents catheter.<br><br>3.1-3(t) | | least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences | | | |

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| | §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. | | | |
| | Based on interview, observations, and record review, the facility failed to ensure the call light was in reach for 1 of 3 residents reviewed for accommodation of needs. (Resident 2)<br><br>Findings include:<br><br>The clinical record Resident 2 was reviewed on 6/15/2023 at 11:45 a.m. The medical diagnoses included dementia and right-hand contracture.<br><br>A Quarterly Minimum Data Set Assessment, dated for 5/10/2023, indicated that Resident 2 was cognitively impaired and had impairment on one upper extremity.<br><br>A fall care plan, dated for 11/12/2021, indicated for Resident 2 to have a call light within reach.<br><br>An observation on 6/8/2023 at 4:47 p.m. indicated Resident 2 was in her room at this time. She was sitting in her wheelchair, facing towards a television on the wall with her call light out of reach.<br><br>An observation on 6/12/2023 at 11:35 a.m., indicated Resident 2 was in her room at this time. She was sitting in her wheelchair, facing towards a television on the wall with her call light out of reach. CRCA 1 verified that Resident 2 could not reach her call light. CRCA 1 indicated she had not seen Resident 2 use her call light in the last couple months. When the call light was placed within reach, the resident was unable to press the button | F 0558 | Resident 2 has call light within reach. Residents with hand contractures have the potential to be affected. DHS or designee will complete an audit of in-house residents to ensure call light is within reach. Nursing staff educated on the Guidelines for Answering Call Lights.<br><br>As a measure of ongoing compliance DHS or designee will audit residents in their rooms to ensure call light is within reach. DHS or designee will audit 5 residents 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br><br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase | 07/07/2023 |

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| | call light.<br><br>A nursing progress note, dated for 6/13/2023, indicated that the button call light was replaced with a soft touch call light.<br><br>A policy entitled, "Guidelines for Answering Call Lights", was provided my Clinical Support RN on 6/15/2023 at 12:20 p.m. The policy indicated, " ...Ensure the call light is plugged in security to the outlet and in reach of the resident ...Adaptive call lights are available if needed ..."<br><br>3.1-3(v)(1) | | frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |
| F 0679<br>SS=D<br>Bldg. 00 | 483.24(c)(1)<br>Activities Meet Interest/Needs Each Resident<br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure a resident had an ongoing activity program. This affected 1 of 3 residents reviewed for activities. (Resident 9)<br><br>Findings include:<br><br>During an interview, on 6/08/23 at 2:03 p.m., Resident 9 indicated she chooses not to go to activities. | F 0679 | Resident 9's care plan has been revised to reflect her activity preferences.<br><br>Residents receiving one on one programming have the potential to be affected. The Life Enrichment Director (LED) or designee will audit in house residents to ensure participation in activities is documented per their plan of care. | 07/07/2023 |

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| | On 6/12/23, at 2:30 p.m., Resident 9 was observed asleep in her recliner, her TV was not on.<br><br>On 6/13/23, at 9:39 a.m., Resident 9 was observed laying on her bed, eyes closed, her TV was not on.<br><br>On 06/13/23, at 2:58 p.m., Resident 9 was observed asleep in her recliner, her TV was off but her roommate's TV was on.<br><br>On 06/14/23, at 3:02 p.m., Resident 9 was observed asleep on her bed.<br><br>On 6/15/23, at 11:10 a.m., Resident 9 indicated activities are lax right now. She said no one comes in and talks to her for a one on one activity every day. She was sitting in her chair and her TV was not on.<br><br>Resident 9's clinical record was reviewed on 6/13/23 at 2:05 p.m. The clinical record indicated Resident 9 had diagnoses that included, but were not limited to, dementia, difficulty swallowing, chronic obstructive pulmonary disease, generalized muscle weakness, depression, macular degeneration, legal blindness, and chronic pain.<br><br>An Annual Minimum Data Set assessment, dated 11/11/2022, indicated Resident 9 was cognitively intact, and activities were music and her favorite activities.<br><br>A care plan, last reviewed 4/18/23, indicated "While in the campus, I may not engage in activities that are meaningful to me because of: I am dx (diagnosed) with Blindness, and dementia. I enjoy listening to Wild Cat games on my TV, visiting with such as mindful mornings. Long | | Activities staff will be educated on the Individual Program Planning policy.<br><br>As a measure of ongoing compliance, the LED will audit residents to ensure activities are documented. LED or designee will audit 5 residents; 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br><br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |

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| | Term Goal Target Date: 07/18/2023 I will accept and/or utilize adaptations and modifications to enable participation in activities that are meaningful to me. Approach Start Date: 12/07/2022 Please engage me in Mindful moment activities to help me manage my dementia at least once a week...Provide me with one to one visits, daily."<br><br>A Live Enrichment Progress note, dated 4/13/23, indicated accommodations utilized for successful participation were: 1:1 settings, verbal instructions and hand under cueing/guidance to support visual impairment, use of her wheelchair, verbal prompts, and supplies placed within reach. The programming participation responses were: her participation level was active, type of participation was independent, large groups, small groups and one to one, participates in activities of expressed importance of pets and favorite activities of listening to KY Wild Cat. The specific programming participation this quarter was mindful moments, theme dinner, celebrated birthday and happy hour. The frequency of visitors indicated daily visits. Her independent activities of interest in which resident participates was watching TV and visits with others. Also she was not interested in changing activity pursuits or trying activities, she was satisfied with current activities.<br><br>Review of May, 2023 activity logs indicated she had 2 one to one visits, she listened to her TV every day, and she had six visits by family, friends, clergy, or pets. She also had her nails done once, had one mindful morning, and had her mail read to her one time by staff.<br><br>Review of June activity logs from June 1 through | | | |

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| | June 13, 2023, indicated she listened to her TV every day, she participated in the traveling garden, had 3 visits by family, friends, clergy, or pets, and had one staff one to one visit.<br><br>The activity logs failed to indicate she had mindful moment activities weekly or daily one to one visits as addressed in her care plan.<br><br>In an interview, on 06/15/23, at 12:05 p.m., the Life Enrichment Director indicated Resident 9 has a lot of one on ones because she is blind and likes to stay in her room. The activity girls see her twice a week and she sees the therapy dogs. She will go to mindful moments if she is up, and staff read her mail to her. She indicated they need to document it better. Life Enrichment Assistant 8 indicated she likes the traveling garden and mindful mornings, and she uses her other senses like smelling and feeling, because she can't see.<br><br>On 6/16/23 at 11:42 a.m., the Executive Director indicated they don't have a specific policy for activities, they follow the regulations.<br><br>3.1-33(a) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | F 0684 | | 07/07/2023 |

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| | Based on interview, observation, and record review the facility failed to obtain orders for a preventive dressing to a non-pressure skin area for Resident 18, failed to obtain treatment orders for a non-pressure skin area for Resident 13, and failed to follow call parameters for Resident 11 for 3 of 14 residents reviewed for compliance for physician orders.<br><br>Findings include:<br><br>1. The clinical record for Resident 18 was reviewed on 6/14/2023 at 2:06 p.m. The medical diagnoses included chronic obstructive pulmonary disease and dementia.<br><br>An Admission Minimum Data Set Assessment, dated for 4/25/2023, indicated Resident 18 was cognitively intact and was at risk for skin impairments.<br><br>An observation on 6/8/2023 at 3:18 p.m. indicated that Resident 18 was sitting in her wheelchair. She had a pink foam dressing applied to the left lower leg without a date or initial upon the dressing.<br><br>An observation on 6/13/2023 at 2:50 p.m. indicated Resident 18 sitting in her wheelchair. She had a pink foam dressing applied to the left lower leg without a date or initials. RN 2 came to resident's room and verified the pink dressing was in place without an indication of date of application. Resident 18 indicated the dressing had been in place "forever". When asked to clarify, she said about a week or so. The dressing was changed to reveal multiple scabbed areas and a scant amount of drainage on the dressing. RN 2 indicated that Resident 18's skin was very fragile and the dressing was more a preventative measure. | | Residents 13 and 18 have treatment orders in place. Resident 11 is no longer a daily weight.<br><br>Residents with non-pressure skin impairments and residents with daily weight orders have the potential to be affected. DHS or designee will complete an audit of in-house residents with non-pressure skin impairments and daily weights to ensure they have physician orders in place and that physician is notified of weight changes per order. Nursing staff will be educated on the Guidelines for Medication Orders.<br><br>As a measure of ongoing compliance DHS or designee will audit residents with non-pressure skin impairments and orders for daily weights to ensure physician orders are followed. DHS or designee will audit 5 residents with non-pressure skin impairments and residents with daily weight orders: 5 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br><br>For quality assurance, The ED | |

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| | Review of the medical record indicated Resident 18 did not have an order for dressings to the left lower leg on 6/8/2023 or 6/13/2023.<br><br>2. The clinical record for Resident 13 was reviewed on 6/14/2023 at 2:49 p.m. The medical diagnoses included stroke and edema.<br>An Admission Minimum Data Set Assessment, dated for 4/26/2023, indicated that Resident 13 was cognitively intact, was at risk for skin impairments, and had pressure areas and skin tear(s).<br><br>An observations on 6/8/2023 at 2:01 p.m. indicated Resident 13 sitting in her wheelchair. She had a pink foam dressing applied to the left knee with no date and had no dressing to the right knee with visible open areas. A scant amount of drainage was noted on her pants.<br><br>A nursing note, dated 6/11/2023, indicated that dressings were changed to Resident 13's knees.<br><br>An observations on 6/12/2023 at 12:59 p.m. indicated that Resident 13 was in bed. She had two pink foam dressings on her knees without any date or initials on the dressing.<br><br>No dressings orders for Resident 13's bilateral knees were on the physician orders.<br><br>A policy entitled, "Guidelines for General Wound and Skin Care", was provided by the Executive Director on 6/14/2023 at 10:00 a.m. The policy indicated, " ...Date, time, and initial all dressings at the time of applications ..."<br><br>3. The clinical record for Resident 11 was reviewed on 6/12/2023 at 11:00 a.m. The medical diagnoses included chronic kidney failure and heart failure. | | and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |

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| | A Quarterly Minimum Data Set Assessment, dated 6/4/2023, indicated Resident 11 had a mild cognitively impairment.<br><br>A care plan, dated for 1/26/2023, indicated for Resident 11 to have weights as ordered.<br><br>A physician order, dated 1/6/2023, indicated for Resident 11 to have daily weights and to call the physician for a three-pound weight gain in 24 hours and/or a five-pound weight gain in five days.<br><br>Review of the medical record indicated that between 1/6/2023 and 4/19/2023, Resident 11 had 14 instances of a weight gain of three pounds, or more, in a 24-hour period. Of these instances, the physician was notified five times.<br><br>An interview with Clinical Support RN, on 6/14/2023 at 3:30 p.m. indicated that the staff should follow physician orders as written, including those to obtain weights and call parameters.<br><br>3.1-37(a) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were | | | |

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| | 155759 | A. BUILDING 00<br>B. WING | 06/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| GLEN OAKS HEALTH CAMPUS | 601 W CR 200 S<br>NEW CASTLE, IN 47362 |

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| | unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, interview and record review the facility failed to follow up with the physician related to a pressure ulcer with increased odor, failed to implement a pressure relieving cushion and failed to complete a thorough and accurate skin assessment for 2 of 6 residents reviewed for pressure ulcers (Resident 36 and Resident 155).<br><br>Findings include:<br><br>1.) Review of the record of Resident 36 on 6/12/23 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, osteomyelitis of vertebra, sacral and sacrococcygeal, stage four pressure ulcer, hypertension, colon cancer and altered mental status.<br><br>The local hospital note for Resident 36, dated 3/27/23, indicated the resident had a pressure ulcer on the sacrum that was red, blanchable and not open. The resident was discharged to the facility on 3/30/23.<br><br>The Admission observation assessment for Resident 36, dated 3/30/23 at 11:16 a.m., indicated the resident had skin impairment (no location or description of wound documented), at high risk for developing pressure ulcers and offloading was the intervention implemented. There was no wound event documented for this skin impairment.<br><br>The Admission Minimum Data Set (MDS) | F 0686 | Resident 155 is discharged. Resident 36 has a wheelchair cushion in place. The physician is aware of the resident's wound status.<br><br>New admission residents and in house residents with pressure ulcers have the potential to be affected. DHS or designee will complete an audit of new admissions for the last 14 days to ensure a skin assessment is documented and in house residents with pressure ulcers to ensure wheelchair cushions are in place. Nursing staff will be educated on Pressure/Stasis/Diabetic wound policy.<br><br>As a measure of ongoing compliance DHS or designee will audit new admission residents to ensure skin assessment is documented and residents with pressure ulcers to ensure wheelchair cushion is in place, if indicated. DHS or designee will audit 5 residents 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued | 07/07/2023 |

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| | assessment for Resident 36, dated 4/4/2023, indicated the resident was severely cognitively impaired. The resident did not have behavior of rejecting care. The resident required extensive assistance of two people for bed mobility and transfers. The resident did not ambulate. The resident was at risk of developing pressure and had one unhealed pressure ulcer.<br><br>The wound assessment for Resident 36, dated 4/4/23, indicated the resident had a unstageable (slough/eschar) on the coccyx measuring 2.5 centimeters (cm) by 1.4 cm.<br><br>The plan of care for Resident 36, dated 4/5/23, indicated the resident was at risk for skin breakdown. The interventions included, but were not limited to, pressure reducing cushion to chair.<br><br>The progress note for Resident 36, dated 4/10/23 at 5:51 a.m., indicated the resident had a strong odor noted from wound.<br><br>The fax to the physician for Resident 36, dated 4/10/23, indicated the resident had increased odor to wound. "Please advise."<br><br>The progress note for Resident 36, dated 4/15/23 at 1:49 p.m., indicated the resident's wound had a foul odor.<br><br>The progress note for Resident 36, dated 4/17/23 at 10:28 a.m.., indicated the resident's wound had a foul odor.<br><br>The progress note for Resident 36, dated 4/19/23 at 10:35 a.m., indicated the resident was out to the wound center. The wound center called and stated the physician wanted to admit the resident resident for wound care and observation. | | compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br><br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |

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The local hospital note for Resident 36, dated 4/19/23, indicated the assessment of the resident was stage 4 pressure ulcer (full thickness loss with exposed bone, tendon or muscle) and osteomyelitis (infection of the bone).

During an observation on 6/13/23 at 2:50 p.m., Resident 36 was sitting in her wheelchair on a pillow, there was no pressure relieving cushion under the pillow.

During an interview with the Nurse Consultant on 6/15/23 at 10:42 a.m., indicated Resident 36 had a stage one pressure ulcer (skin intact with redness and non blanchable) on admission from the hospital and there was no wound event completed for the stage one pressure ulcer. The facility would not necessarily complete a wound event for stage one pressure ulcer.

During an interview the Director Of Health Services (DHS) on 6/15/23 at 1:35 p.m., indicated the physician did not respond to the fax sent on 4/10/23 related to Resident 36's wound having an increase in odor and the physician did not evaluate the resident's wound.

During an interview with the DHS on 6/15/23 at 1:40 p.m., indicated the nurses were responsible to follow up with the physician when there was no response from the 4/10/23 fax about resident 36's wound with an increase in odor. The facility would expect a response from a fax to the physician within 1 to 2 days.

2.) Review of the record of Resident 155 on 6/13/23 at 2:01 p.m., indicated the resident's diagnoses included, but were not limited, acute

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respiratory failure with hypoxia, pleural effusion, chronic obstructive pulmonary, dementia and chronic kidney disease.

The Admission Minimum Data Set (MDS) assessment for Resident 155, dated 6/5/23, indicated the resident was severely impaired for daily decision making. The resident was extensive assistance of two staff for bed mobility, transfers and did not ambulate. The resident was at risk of developing a pressure ulcer and had an unhealed pressure ulcer. The resident was admitted to the facility on 6/5/23.

The progress note for Resident 155, dated 6/7/23 at 10:07 a.m., indicated the resident was complaining of right ankle pain and upon assessment found a douderm dressing dated 5/29/23, which was prior to admission to the facility. The area looked like a stage two pressure ulcer, with redness and edema, very tender to touch. Cleaned area and applied a new dressing. The ankle was wrapped and an ice pack placed for pain and swelling.

The progress note for Resident 155, dated 6/7/23 at 11:54 a.m., indicated the resident had a wound on the right lateral ankle over bone measuring 0.5 cm by 0.7 cm. The area was yellow/pink. The margins white/soft in appearance, light serous drainage noted to old dressing. A foam dressing was applied.

The wound assessment for Resident 155, dated 6/7/23, indicated the resident had an unspecified ulcer of the right lateral ankle. Wound bed pale yellow/pink. Margins white/soft. Periwound reddened; blanches. Foam dressing applied over site. Measuring 0.5 centimeter (cm) by 0.7 cm.

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| | During an interview with DHS on 6/15/23 at 2:20 p.m., indicated it was the admitting nurse who was responsible to complete a thorough and accurate skin assessment and initiate a treatment for Resident 155.<br><br>The notification of change in condition provided by the Executive Director on 6/15/23 at 10:40 a.m., indicated the purpose was to ensure appropriate individuals are notified of change in condition. The facility must inform the resident's physician when there was a significant change in the resident's physical status or a need to alter treatment significantly. Sample reasons to notify the physician immediately included, but were not limited to, a deterioration in health status in either life threatening conditions or clinical complications and a need to alter treatment significantly.<br><br>The pressure ulcer policy provided by the Nurse Consultant on 6/15/23 at 12:20 p.m., indicated appropriate wound event is completed by a nurse in the electronic health record for each impaired skin area with measurements, color, odor, wound margins, surrounding tissue, exudate and tunneling. The purpose was to provide weekly documentation of wound measurements and condition.<br><br>3.1-40(a)(2) | | | |
| F 0695<br>SS=D<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including | | | |

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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 maintain an nebulizer machine in sanitary manner, failed to change the tubing monthly and failed to have oxygen tubing dated for 3 of 7 residents reviewed for respiratory care (Resident 15, Resident 37 and Resident 3).<br><br>Findings include:<br><br>1.) During an observation on 6/08/23 at 3:54 p.m., Resident 15 nebulizer tubing was dated 4/17/23, the oxygen tubing did not have a date on it.<br><br>During an observation and interview with Resident 15 on 6/12/23 at 1:56 p.m., the resident's nebulizer mask was laying on the bedside table, Resident 15 indicated she did not know where the bag was to store it in. The resident searched for a bag to store it in, but was unable to locate one.<br><br>Review of the record of Resident 15 on 6/12/23 at 2:20 p.m., indicated the resident's diagnoses included, but were not limited to, Chronic respiratory failure with hypoxia, Chronic obstructive pulmonary disease with (acute) exacerbation, Unspecified fall, osteoarthritis, Unsteadiness on feet, repeated falls, dependence on supplemental oxygen and difficulty in walking.<br><br>The physician order for Resident 15, dated 4/12/23, indicated the resident was ordered Albuterol sulfate solution for nebulization three times a day. | F 0695 | Residents 15, 3, and 37 have dates and storage bags for nebulizers and/or oxygen supplies.<br><br>Residents receiving oxygen and nebulizer treatments have the potential to be affected. DHS or designee will complete an audit of in-house residents with orders for oxygen or nebulizer treatments to ensure all supplies are dated and stored appropriately. Nursing staff will be educated on the respiratory equipment policy.<br><br>As a measure of ongoing compliance DHS or designee will audit residents with orders for nebulizers and/or oxygen to ensure supplies are dated and stored per policy. DHS or designee will audit 5 residents 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. | 07/07/2023 |

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| | The physician order for Resident 15, dated 6/14/23, indicated the resident was ordered oxygen at 2.5 liters nasal cannula continuous.<br><br>During an interview with the Director of Health Services (DHS) on 6/13/23 at 12:00 p.m., the nurse on night shift was suppose to change oxygen tubing weekly on Sundays and are responsible to date oxygen tubing and keep nebulizer in a mask. The facility policy says monthly, but the DHS preferred it be done weekly.<br><br>During an interview with the Executive Director on 6/14/23 at 1:25 p.m., Resident 15 did not have an order for oxygen until today, she should of had an order. The resident had went to the hospital and when she came back the facility did not get an order.<br>2. The clinical record for Resident 3 was reviewed on 6/14/2023 at 2:14 p.m. The medical diagnoses included respiratory failure and heart failure.<br><br>A Quarterly Minimum Data Set Assessment, dated 5/15/2023, indicated that Resident 3 was cognitively intact and utilized oxygen therapy.<br><br>An observation on 6/8/2023 indicated Resident 3 sitting in his motorized chair utilizing portable oxygen. He had a nasal cannula in place. No date was on the nasal cannula, nor a storage bag noted for the portable oxygen tubing.<br><br>An observation on 6/12/2023 at 4:05 p.m. indicated Resident 3 was sitting in his motorized chair utilizing portable oxygen. He had a nasal cannula in place. No date was on the nasal cannula, nor a storage back noted for the portable oxygen tubing.<br><br>3. The clinical record for Resident 37 was reviewed | | For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |

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| | on 6/15/2023 at 10:55 a.m. The medical diagnoses included respiratory failure and pneumonia.<br><br>A Quarterly Minimum Data Set Assessment, dated 5/12/2023, indicated that Resident 37 was cognitively impaired and utilized oxygen therapy.<br><br>An observations on 6/9/2023 at 12:26 p.m. indicated that the portable oxygen nasal cannula tubing did not have a date, but a bag on the back of the Geri chair was dated for "4/17".<br><br>An observation on 6/12/2023 indicated that Resident 37 was sitting in her Geri chair. She had her portable oxygen therapy in place. The nasal cannula did not have a date, but an oxygen storage bag was on the back off the chair dated "4/17". CRCA 1 verified no date on the tubing, but the date of "4/17" on the storage bag. She immediately changed the oxygen set up and tubing.<br><br>A policy entitled, "Administration of Oxygen", was provided by the Executive Director on 6/13/2023 at 2:15 p.m. The policy indicated, " ...Date the tubing for the date it was initiated ...Tubing should be changed monthly and PRN [as needed] ..."<br><br>3.1-47(a)(6) | | | |
| 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. | | | |

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| | §483.45(h) Storage of Drugs and Biologicals<br><br>§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. | | | |
| | Based on interview, observation, and record review, the facility failed to ensure Resident 18 did not have medications at bedside for 1 of 6 residents reviewed for medication administration.<br><br>Findings include:<br><br>The clinical record for Resident 18 was reviewed on 6/14/2023 at 2:06 p.m. The medical diagnoses included chronic obstructive pulmonary disease and dementia.<br><br>An Admission Minimum Data Set Assessment, dated for 4/25/2023, indicated Resident 18 was cognitively intact and was at risk for skin impairments.<br><br>The clinical record did not indicate that Resident 18 could self-administer medications. | F 0761 | Medications were removed from resident 18's room.<br><br>All residents have the potential to be affected. DHS or designee will complete an audit of in house residents to ensure medications are not left at bedside for residents that do not self-administer medications. Nurses will be educated on the Medication Administration Guidelines.<br><br>As a measure of ongoing compliance DHS or designee will audit residents that do not self administer medications to ensure medications are not left at bedside. DHS or designee will | 07/07/2023 |

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| | Review of the medical record indicated that Resident 18 did not have an order for Systane or Refresh eye drops.<br><br>A physician order, dated 6/8/2023, indicated for Resident 18 to utilize a Spiriva inhaler 2 puffs daily.<br><br>An observation on 6/12/2023 at 11:30 a.m. indicated that Resident 18 had a Spiriva inhaler, a bottle of Systane eye drops, and a bottle of Refresh eye drops on her beside table.<br><br>An observation on 6/12/2023 at 1:45 p.m. indicated that Resident 18 had a Spiriva inhaler, a bottle of Systane eye drops, and a bottle of Refresh eye drops on her beside table.<br><br>An observation on 6/13/2023 at 3:02 p.m. indicated that she Systane eye drops, and Refresh eye drops on her beside table. She indicated her family had brought in the eye drops awhile back, but she does not use them that often. She indicated the nurses bring in her inhaler and usually leave it for her to take as she gets up then will pick it up at the end of their shift.<br><br>An interview with RN 2 on 6/13/2023 at 3:06 p.m. indicated she did not believe Resident 18 could self-administer her inhaler or eye drops. She told Resident 18 was going to place the eye drops in the medication cart.<br><br>An interview with the Director of Health Services on 6/15/2023 at 2:55 p.m. indicated that Resident 18 does not self-administer medications and medications should not be let at the bedside.<br><br>Review of the medical record indicated that | | audit 5 residents 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br><br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. | |

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| | Resident 18 did not have an order for Systane or Refresh eye drops.<br><br>A policy entitled, "Medication Storage in the Facility", was provided by the Executive Director on 6/16/2023 at 11:40 a.m. The policy indicated, " ...medications intended for internal use are storage in a medical cart or other designated area ..."<br><br>3.1-25(m) | | | |
| F 0842<br>SS=D<br>Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155759 | A. BUILDING 00<br>B. WING | 06/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| GLEN OAKS HEALTH CAMPUS | 601 W CR 200 S<br>NEW CASTLE, IN 47362 |

| (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 |
|---|---|---|---|---|
| | law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic | | | |

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| GLEN OAKS HEALTH CAMPUS | 601 W CR 200 S<br>NEW CASTLE, IN 47362 |

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| | services reports as required under §483.50.<br><br>Based on interview and record review, the facility failed to complete to complete an inventory sheet for Resident 11 for 1 of 3 reviewed for inventory sheets.<br><br>Findings included:<br><br>The clinical record for Resident 11 was reviewed on 6/12/2023 at 11:00 a.m. The medical diagnoses included chronic kidney failure and heart failure.<br><br>A Quarterly Minimum Data Set Assessment, dated 6/4/2023, indicated Resident 11 had a mild cognitively impairment, was moderately hard of hearing, and utilized assistive devices for hearing.<br><br>An interview with Resident 11's Power of Attorney (POA), indicated that Resident 11 had hearing aids when she was admitted to the facility. The POA indicated that Resident 11 has lost her hearing aids and they have not been replaced yet, but she would like Resident 11 to see audiology services.<br><br>A review of Resident 11 record indicated that no inventory sheet was completed at admission.<br><br>An interview with the Executive Director on 6/14/2023 at 3:35 p.m. indicated that no inventory sheet was completed for Resident 11. The facility does not have a policy for inventory sheets, but it is the expectation that these are completed at the time of admission.<br><br>3.1-50(a)(1) | F 0842 | An inventory of resident belongings was completed for resident 11.<br>New admission residents have the potential to be affected. DHS or designee will complete an audit of in-house residents to ensure residents have an inventory of personal belongings completed.<br>Nursing staff will be educated on the Matrix Admission Checklist.<br>As a measure of ongoing compliance DHS or designee will audit new admission residents to ensure a resident inventory is completed upon admission. DHS or designee will audit 5 residents 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br>For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing | 07/07/2023 |

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| | | | monitoring will continue past 6 months if warranted until 100% compliance met. | |
| 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 Investigation of Complaint IN00409075.<br><br>Complaint IN00409075-No deficiencies related to the complaint are cited.<br><br>Survey dates: Survey dates: June 8, 9, 12, 13, 14, 15, and 16, 2023<br><br>Facility number: 011187<br><br>Residential Census: 22<br><br>Glen Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.<br><br>Quality review completed on June 20, 2023 | R 0000 | Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the annual survey conducted on June 16, 2023. Please accept this Plan of Correction as the provider’s credible allegation of compliance as of July 7, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance | |