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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health Campus	1143 23rd St Tell City, IN 47586

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46416 Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 3 residents reviewed for receiving oxygen therapy. A resident's oxygen concentrator and portable oxygen tank were not set at the ordered Liters Per Minute (LPM). (Resident 13) Finding includes: On 6/24/24 at 10:23 A.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per nasal cannula (NC) that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 2 LPM. The tubing was not dated. There was an oxygen concentrator machine at bedside with a dusty filter. On 6/27/24 at 9:49 A.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per NC that was connected to the oxygen concentrator machine at bedside with the setting on at 1.5 LPM and the NC tubing was resting on top of the resident's nose. The filter of the oxygen concentrator machine was dusty. On 6/27/24 at 1:25 P.M., Resident 13 was observed sitting in his room in his wheelchair wearing oxygen per NC that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 0.5 LPM. On 6/27/24 at 1:30 P.M., Registered Nurse (RN) 26 observed the resident in the bathroom with staff toileting him and the resident wearing oxygen per NC that was connected to a portable oxygen tank on the back of his wheelchair with the setting at 0.5 LPM. The resident indicated he was not short of breath. She proceeded to take the resident's oxygen saturation and it read 91-92%. At that time, she adjusted the resident's portable oxygen tank setting to 2 LPM. On 6/27/24 at 12:21 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, hypertension, and heart failure. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated Resident 13's cognition was moderately impaired, he was an extensive assist of 2 staff for bed mobility, transfers, toileting, and on oxygen. Current Physician's Orders included, but were not limited to, the following: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change oxygen tubing monthly once a day on the 1st of the month, dated 3/14/24 Clean external concentrator filter every two weeks once a day on Sunday, dated 3/14/24 Oxygen at 2 LPM per NC, continuously, three times a day, ordered 3/14/24 A current Congestive Heart Failure (CHF) Care Plan, revised 5/20/24, included, but was not limited to, the following interventions: Oxygen per MD orders, initiated 3/7/24 On 6/27/24 at 1:13 P.M., the June 2024 Treatment Administration Record (TAR) was reviewed and indicated the external filter was cleaned on 6/23/24 and the resident's oxygen saturation levels ranged from 94-98% while wearing oxygen. During an interview on 6/27/24 at 1:35 P.M., RN 18 indicated the nurse was responsible for making sure the oxygen setting was as ordered and moving the residents oxygen tubing from the portable tank to the concentrator should be done by the nurse. She was not sure how long the resident had been connected to his portable oxygen tank because she observed the resident on his oxygen via the concentrator machine before lunch but had not looked at his oxygen after. At that time, she indicated his normal oxygen saturation would be in the upper 90's, like 95-97%, with his oxygen on. She indicated the oxygen setting on the oxygen concentrator machine should be checked every shift when the resident was connected to it and as needed and the portable tank should be checked when resident was first connected to it and as needed. On 6/28/24 at 11:57 A.M., a current Respiratory Care Policy and/or a Following Physician's Orders Policy was requested and the Regional Support indicated there was not a policy for following the physician's orders but it would be the policy for staff to follow orders. 3.1-47(a)(6)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46882 Based on observation, interview, and record review, the facility failed to ensure Posted Nurse Staffing sheets contained the correct information daily for 1 of 6 days reviewed during the survey. (6/24/24) Findings include: On 6/24/24 at 10:39 A.M., the Posted Nurse Staffing was observed hanging on the wall across from the 100, 200, and 300 nurses' station dated 6/14/24. During an interview on 6/28/24 at 11:58 A.M., the DON (Director of Nursing) indicated that the scheduler hung the Posted Nurse Staffing first thing in the morning. The DON indicated that she had been doing it while the scheduler was out for the last few days. On 6/28/24 at 12:07 P.M., the DON provided a Guidelines for Staff Posting Policy, revised 5/11/16, which indicated Purpose was to ensure compliance with federal regulations posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46416 Based on observation, record review and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents observed for a medication pass and 1 of 3 observed for incontinence care. During a med pass, pills were dropped on the medication cart and administered to a resident. Staff did not use hand hygiene between glove changes during care. (Resident 35, Resident 9) Findings include: 1. On 6/27/24 7:14 A.M., Registered Nurse (RN) 12 was observed preparing and passing medications to Resident 35. After RN 12 prepped all 16 of the resident's pills into medication cups, she put on gloves and knocked one of the medication cups over spilling out the resident's Keppra (anticonvulsant), Namenda (cognition enhancing), and docusate sodium (stool softener) onto the medication cart. RN 12 picked them up with her gloved hand, put them back into the medication cup, took the pills out of the cup that needed to be crushed and crushed them. Then she opened the pills that were capsules and dumped all the medications together, put chocolate pudding into the cup, and administered them to the resident. During an interview on 6/27/24 at 2:38 P.M., the Infection Preventionist (IP) indicated any pills dropped onto a medication cart while preparing medications for a resident should be disposed of and the person preparing the medications should get new ones to administer to the resident. 45933 2. During an observation on 6/27/24 at 11:16 A.M., Certified Nurse Aide (CNA) 28 assisted Resident 9 to the restroom. CNA 28 removed Resident 9's soiled brief with gloved hands, grabbed the new brief, and placed it on the resident, removed gloves, donned new gloves, and wiped stool off resident 9's bottom. At that time, CNA 28 failed to remove gloves and perform hand hygiene before Resident 9's brief was pulled up. At that time, hand washing was performed for a 5 second lather. During an interview on 6/27/24 at 2:38 P.M., the Infection Preventionist (IP) indicated staff should perform hand hygiene between glove changes. During an interview on 6/28/24 at 9:46 A.M., Registered Nurse (RN) 12 indicated staff should lather for 20 seconds when hand hygiene is performed. On 6/28/24 at 8:00 A.M., a current Medication Administration Preparation General Guidelines Policy, revised January 2018, was provided by Regional Support and indicated Medications are administered as prescribed in accordance with good nursing principles and practices . after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 12:13 P.M., the Director of Nursing (DON) provided a Guideline for Handwashing/Hand Hygiene policy, revised 2/9/17 that indicated, .Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of antiseptic hand rub, also known as alcohol-based hand rub .d. After removing gloves .Wash well for at least 20 seconds, using a rotary motion and friction . 3.1-18(b) 3.1-18(l)