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	08/20/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide a resident appropriate care and services for 1 of 1 resident reviewed for hospitalizations. The resident was not thoroughly assessed, physician's orders were not followed, and staff were not adequately trained to provide care of a resident with a recent vascular stent placement. This deficient practice resulted in the resident being hospitalized . (Resident 89) Finding includes:On 8/14/25 at 1:01 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but were not limited to, peripheral vascular disease (PVD).The most recent quarterly MDS (Minimum Data Set) assessment prior to the resident's discharge, dated 3/1/25, indicated Resident 89 was cognitively intact, supervision of staff for bed mobility, transfers, showering, and toileting, and had not rejected care.The most recent discharge MDS assessment, dated 5/26/25, indicated Resident 89's cognition was not assessed, supervision of staff for bed mobility, transfers, showering, and toileting, and she did not reject care.On 4/24/25, the resident had an arterial doppler study of both legs for PVD and a nonhealing ulceration of the left lower leg. It was abnormal and showed significant disease in the left distal (far end) superficial femoral artery (SFA) and proximal (close end) popliteal (behind the knee) artery and stenosis (narrowing) of the iliac artery. Stent placement was recommended by the vascular surgeon.On 5/20/25, Resident 89 left the facility and underwent a planned, same day angioplasty and stent placement procedure in the left leg (a minimally invasive procedure using a balloon-tipped catheter to widen the artery and then placing a small mesh tube or stent inside the artery to keep it open and improve blood flow).Post Procedure (post-op) Discharge Instructions from the vascular surgeon were provided to the facility, dated 5/20/25, and included, but were not limited to, the following orders for Resident 89 after her procedure:-Observe the procedure site for signs of infection: redness, swelling, warmth, drainage, or foul odor-Resume medications as previously instructed, aspirin (antiplatelet) 81 milligrams (mg) by mouth daily and Plavix (antiplatelet) 75 mg by mouth daily (handwritten and circled under medication instructions)-contact the physician for increasing or severe pain, shortness of breath, weakness or dizziness, fever, redness, swelling, warmth, or bleeding at the puncture siteThe clinical record lacked a care plan for Resident 89's post-op stent placement.Nursing Progress Notes included, but were not limited to, the following:On 5/7/25, the resident returned, with family, from an appointment with the vascular surgeon. The resident was scheduled for the procedure on 5/20/25.On 5/20/25, the resident had returned to the facility from the procedure at 5:22 P.M., with pressure dressing on her left groin to be removed at noon on 5/21/25. Staff were to resume all medications and observe the procedure site for signs of infection: redness, swelling, warmth, drainage or foul odor.A New Skin Occurrence Assessment, dated 5/21/25, was completed for a bruise on the left upper thigh and groin area. New measures taken to prevent recurrence were to ensure the resident has appropriate treatments implemented, encourage the resident to drink fluids, and to apply moisturizer to keep skin supple.On 5/23/25 at 12:30 P.M., the nurse practitioner was there to evaluate the patient. Resident indicated she had pain in her left foot and did not sleep well. No lower extremity edema was observed, distal pulses were present, and vital signs were within normal limits. Current orders were reviewed and a new prescription for Melatonin (sleep aide) was ordered at that time.On 5/26/25 at 7:28 A.M., a weekly skin assessment was completed at this time with no new skin issues noted.Nursing progress (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	notes continued:On 5/26/25 at 8:00 A.M., the nurse noticed the resident was upset, asking where she was, and saying she was more confused than usual at that time. The nurse reoriented resident and exited the resident's room.On 5/26/25 at 8:11 A.M., the Certified Nurse Aide (CNA) approached the nurse and indicated she was worried about the resident because the resident was unsure of her surroundings, had trouble comprehending what the CNA said to her, and was unable to carry on a conversation with the CNA like she usually did. Nursing would continue to monitor the resident. On 5/26/25 at 4:45 P.M., the resident was noted to have slurred speech and twitching. The resident's left lower leg was purple, cool to touch, and swollen. An order was obtained from the physician to send the resident to the emergency room (ER) for evaluation at that time.The history and physical from the hospital ER, dated 5/26/25, indicated the resident had peripheral arterial disease and was status post angioplasty and stent placement a few days ago who presented to (hospital name) from (facility name). The resident was on aspirin and Plavix for peripheral stent placement. Yesterday she was noted to have slurred speech and appeared tired as reported by her daughter. Testing on the left leg showed presence of a distal SFA popliteal stent which was occluded.A hospital progress note, dated 6/3/25, indicated it was discovered that the resident was not receiving Plavix 75 mg daily at the facility as ordered by the vascular surgeon.The Medication Administration Record (MAR) for May 2025 indicated the direct pressure dressing was removed at 10:42 A.M., (1.5 hours early) per the resident's request. The ordered medication Plavix 75 mg daily was not administered.The clinical record lacked documentation of the following:-a physician's order to remove the direct pressure dressing early-education provided to the resident about the risks and benefits of removing the dressing early-physical assessments and monitoring of the resident's temperature and left lower leg for pain, redness, swelling, warmth, drainage, bleeding, and foul odor, as ordered-notification to the physician about the sudden mental status changeThe facility assessment, last reviewed 8/7/25, indicated . If a resident who currently resides at the campus develops a new diagnosis, condition, or symptom which the campus is less familiar with, the campus Executive Director and Director of Health Services will review the skills and competencies of the current staff and may determine whether the current staffing provides the appropriate resources to care for the resident, or they may obtain additional resources (either internal or external) to meet the needs of that resident . During an Interview on 8/18/25 at 11:29 A.M., Registered Nurse (RN) 2 indicated the admitting nurse was responsible for putting orders from the hospital discharge into the electronic health record and another nurse would verify them for accuracy. For resident's that have incisions, nurses should assess for redness, swelling, pain, drainage and document findings in the Medication Administration Record (MAR) or a progress note. If abnormal findings occurred, the nurse should start an event for tracking purposes. Usually for post-op residents, there were protocols to put in place, but she was not sure if there was one for post op stent care. The nurse would use their discretion about notifying the physician of changes. If it was something out of the ordinary, they would text, fax, or call them depending on the urgency. During an Interview on 8/18/25 at 12:00 P.M., the Infection Preventionist (IP) indicated she administered the in services and education for the clinical staff. Post-op stent training for the nurses was not done because usually the hospital kept the residents until the dressing was removed and then sent very detailed follow up orders on what to do and how to monitor the resident post op. She indicated the Post Op Discharge Instructions from the procedures were placed in a binder at the nurse's station, so they were readily available for the nurse to refer back to for discharge orders. Nurses were trained to follow the orders for post op assessments and care. If the resident requested to take the direct pressure dressing off early, they should call the doctor for an order first. The orders for post-op-stent care and outcomes would be documented in progress notes and/or the MAR so staff could keep better track of findings. She was unable to provide additional documentation of a physician's order to remove the direct pressure dressing early, education provided to the resident about the risks and benefits of removing the dressing early, physical assessments and monitoring of the resident's temperature and left lower leg for pain, redness, swelling, warmth, drainage, bleeding, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and foul odor, as ordered, and notification of the doctor being notified when the resident had mental status changes.Interview on 8/18/25 at 1:37 P.M., Regional Support indicated it was not ordered to check pulses or perform other assessments on the resident's leg post op, only monitor the bruising. Long Term Care (LTC) didn't do those kinds of assessments if they were not ordered. Usually, all the acute care was done at the hospital, and residents were stable when they were released back to the facility. She indicated Resident 89's condition was a sudden change before they sent her to ER.Interview on 8/19/25 at 8:37 A.M., the facility pharmacy indicated they did not receive an order for Plavix from the facility for the resident in May of 2025.Interview on 8/19/25 at 9:02 A.M., RN 4 indicated the staff usually did not have many post-op residents, but they have protocols to follow when they were post-op and she would assess the resident according to those and any physician discharge orders. They should follow orders on how to do the dressings. The discharge orders were entered within so many hours of the resident returning and they were verified by another nurse. Pharmacy requests for new medications should be sent by a nurse as soon as possible.Interview 8/19/2025 at 9:20 A.M., the Director of Nursing (DON) indicated she was aware the resident was going to have the procedure and return to the facility. The Post Op Discharge Instructions were placed in the binder at the nurse's station for the nurses to refer to for the orders. Nurses were trained to follow the orders for post op assessments and care. She was unaware of the reason the resident was not started on Plavix 75 mg daily as ordered on Post Op Discharge Instructions given to the facility on 5/20/25.Interview on 8/20/25 at 8:54 A.M., the Administrator and Clinical Support provided a Post Office Visit Summary from the vascular surgeon, dated 5/7/25, that indicated Plavix 75 mg daily should have been started on 5/7/25 when Resident 89 returned to the facility from that appointment. At that time, they both indicated they had not received that new order. They indicated if nursing noticed the Plavix 75mg daily handwritten under medications on the Post Op Discharge Instructions as a discrepancy, no one questioned it and clarified the medication order with the physician at that time.On 8/20/25 at 8:00 A.M., a current RN job description summary was provided by the administrator and indicated The Registered Nurse (RN) is primarily responsible to provide quality care . efficient, safe, and effective care of patients through use of available resources and adherence to the Health Campus Policies and Procedures . utilize the nursing process in delivering patient care and ensure continuity of care from admission through discharge . Notify the charge nurse, the physician, and/or the DHS [DON] when there is a change in the resident's condition . Administer and document medication and treatments per the physician's order and accurately record all care provided . Perform and document a comprehensive assessment on each assigned resident . Develop an accurate comprehensive care plan based on each resident's comprehensive assessment . Review and understand the care plan for each assigned resident . Document resident care provided and resident's response or lack of response to care provided . Assess resident needs and initiate development of individualized plans of resident care . Must be knowledgeable of nursing and medical practices and procedures . On 8/20/25 at 12:29 P.M., the Administrator indicated there was not a policy for monitoring post-op patient. At that time, she indicated they would follow the discharge instructions given.3.1-37(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 5 residents reviewed for unnecessary medications and 1 of 1 residents reviewed for dialysis. Care plans lacked resident specific diagnoses and interventions. (Resident 1, Resident 33, Resident 54, Resident 55, Resident 86)Findings include:1. On 8/15/25 at 12:34 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, osteoarthritis, anxiety, and depression. The most recent admission Minimum Data Set (MDS) assessment, dated 7/30/25, indicated resident 54 was cognitively intact and partial to moderate assistance of staff (staff performs less than half the effort) for transfers and toileting. A current Activities of Daily Living (ADL) Care Plan, last reviewed 7/24/25, indicated Resident has potential for decline in functional status r/t [related to] ___DX ____ [diagnosis]. The care plan lacked resident specific diagnoses related to the potential for functional decline. 2. On 8/14/25 at 10:43 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety, and depression. The most recent admission Minimum Data Set (MDS) assessment, dated 7/1/25, indicated a severe cognitive impairment, and was independent with eating, toileting, showering, bed mobility, and transfers. Current physician orders included, but were not limited to: buspirone (an antianxiety medication) 15mg (milligram) twice a day for generalized anxiety disorder, dated 8/11/25. A current care plan for psychotropic drug use, dated 8/1/25, indicated receiving antianxiety medication for: The care plan did not indicate the reason for the antianxiety medication. Resident 33's clinical record lacked a care plan related to behaviors. Resident 33's clinical record lacked a care plan related to self harm and threats of suicide. Progress notes from July and August 2025 indicated, but was not limited to, the following behaviors: 7/7/25 Restless and anxious, cursing at staff, and throwing items. 7/19/25 Pacing, cursing at staff, punching walls and doors, screaming, hitting self, threats of suicide. 7/22/25 Repetitive questions, smacking self, cursing at staff. 7/23/25 Fixative, anxiety, yelling, cursing at staff, hitting walls and doors, smacking self. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/24/25 Fixative, refusals, anger, threats of suicide. 7/26/25 Cursing, repetitive questions, smacking self, other self harm, agitation. 7/28/25 Threats of suicide, self harm. 8/13/25 Agitation and anxiety, cursing at staff, refusals. 8/16/25 Agitation, cursing at staff, anxiety. During an interview on 8/18/25 at 9:45 A.M., Certified Nurse Aide (CNA) 7 indicated staff were made aware at admission that Resident 33 had a history of suicidal threats and behaviors. 3. On 8/14/25 at 1:29 P.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, and depression. The most recent significant change Minimum Data Set (MDS) assessment, dated 6/3/25, indicated no cognitive impairment, partial to moderate (helper does less than half the effort) assistance with toileting, showering, bed mobility, and transfers, and use of an opioid (pain medication). A current pain care plan, dated 7/22/24, indicated At risk for pain r/t [related to] __DX__ [diagnosis]. The care plan did not specify what diagnosis the pain was related to. A current activities of daily living care plan, dated 7/22/24, indicated Resident has potential for decline in functional status r/t ___DX____. The care plan did not specify what diagnosis the potential for decline was for. 4. On 8/15/25 at 9:40 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/26/25, indicated moderate cognitive impairment. A current pain care plan, dated 10/17/23, indicated At risk for pain r/t [related to] __DX__ [diagnosis]. The care plan did not specify what diagnosis the pain was related to. A current activities of daily living care plan, dated 10/17/23, indicated Resident has potential for decline in functional status r/t ___DX____. The care plan did not specify what diagnosis the potential for decline was for. 5. On 8/14/25 at 1:34 P.M. Resident 55's clinical record was reviewed. Diagnoses included, but were not limited to, end-stage renal disease, dependent on renal dialysis, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/12/25, indicated Resident 55 was cognitively intact. A current activities of daily living care plan, dated 3/23/24, indicated Resident has potential for decline in functional status r/t ___DX____. The care plan did not specify what diagnosis the potential for decline was for. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/19/25 at 1:40 P.M., the MDS Coordinator indicated that she would not expect the diagnoses to be specific due to multiple comorbidities that each resident had. At that time, the Social Services director indicated she is in charge of implementing care plans related to behaviors and specific behaviors should be care planned and initiated within 7 days On 8/20/25 at 12:23 P.M., a Comprehensive Care Plan Guideline policy, dated 5/22/2018 was provided by the Administrator and indicated, .b. Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident. c. Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan. d. A comprehensive care plan will be developed within 7 days of completion of the.comprehensive assessment .to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines . Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident . Comprehensive care plans need to remain accurate and current . 3.1-35(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was served in accordance with professional standards for 1 of 1 kitchen observed. Staff picked food up with soiled gloves, placed on top of resident's food, and served plate to residents. (Kitchen)Finding includes:During a dining room observation on 8/13/25 at 11:39 A.M., three residents were observed sitting at a table. Each plate at the table was observed with a plastic packet of butter sitting on top of the food. At that time, kitchen staff member was observed to bring out a plate of food from the kitchen with a plastic butter packet sitting on top of the food on the plate. It was then served to a resident. On 8/13/25 at 11:52 A.M., Kitchen Staff 23 was observed plating food in the kitchen. Kitchen Staff 23 grabbed clean plates with both thumbs over the lip of the plates, and placed them in the serving line. After washing her hands, she put gloves on and grabbed meal tickets from Kitchen Staff 55 (that she brought in to the kitchen from the dining room). She shuffled through the meal tickets, grabbed a plate with her thumb over the lip of plate, and handled the serving utensils. Kitchen Staff 23 grabbed a piece of cornbread and a butter packet with the same gloves, and placed them on top of the food on the plate. During an interview on 8/15/25 at 9:27 A.M., the Dietary Manager indicated there was one kitchen for serving both assisted living and health center. At that time, she indicated staff should treat glove use like bare hands on serving line. Bread and other food should be picked up with tongs and placed on the resident's plate, not gloves. On 8/20/25 at 7:54 A.M., a current infection control policy related to food handling was requested and not provided during the duration of the survey. 3.1-21(i)(2) 3.1-21(i)(3)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's antipsychotic was changed without attempts of non-pharmacological interventions, and received more than the recommended dose of an antipsychotic medication when switching from one antipsychotic medication to another. (Resident 33)Finding includes:On 8/14/25 at 10:43 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and depression. Resident 33 was admitted on [DATE]. The most recent admission Minimum Data Set (MDS) assessment, dated 7/1/25, indicated a severe cognitive impairment, and use of an antipsychotic medication. Physician orders included, but were not limited to:Rexulti (an antipsychotic) 2mg (milligram) tablet once a day, dated 6/24/25 through 7/21/25. Rexulti 1mg tablet once a day, dated 7/22/25 through 7/26/25.Risperdal 0.5mg tablet at bedtime, dated 7/21/25 through 7/23/25. Risperdal 1mg tablet at bedtime, dated 7/23/25 through 7/28/25. Risperdal 1.5mg at bedtime, dated 7/28/25 through 7/28/25.A current care plan for psychotropic drug use, dated 6/25/25, included, but was not limited to, an intervention to attempt to give the lowest dose possible. Behaviors leading up to the change of antipsychotic medication included, but were not limited to, the following:A nursing note on 7/17/25 at 2:35 P.M. indicated Resident 33 had been very anxious and agitated all day, consistently demanding to see her husband not remembering him coming that morning. Resident 33 cursed at staff and had no interest in activities offered. Resident 33 hollered out, cursed, and repeatedly smacked her hands together hard and loudly. Other than activities, no other intervention was documented. A nursing note on 7/19/25 at 7:48 A.M. indicated Resident 33 had been pacing the hall and repetitively asked for spouse. The resident had been verbally aggressive with staff for several hours. Every 10-15 minutes, resident asked for spouse and the reason she was in the facility, and after every episode staff reminded her that spouse would be there later to visit, resident became agitated, cursing at staff and punched the door and walls in her room. Staff suggested other methods of expressing anger but resident was unaccepting. Resident denied being a patient, refused to eat breakfast, and knocked medications out of the nurse's hands onto the floor. The nurse then left the resident in her room to calm down. A nursing note on 7/19/25 at 2:28 P.M. indicated Resident 33 was pacing the hall, cursing at staff, screaming, and punching walls and doors with fist. Resident was beating on chest and putting her hands around her throat as if to choke herself. Resident kept repeating threats to kill herself while placing her hands over her mouth and nose. No intervention was documented. A nursing note on 7/21/25 at 12:19 P.M. indicated the psych Nurse Practitioner (NP) had seen the resident and gave orders to decrease Rexulti to 1mg daily for 5 days, then discontinue and to start Risperdal 0.5mg. A nursing note on 7/22/25 at 2:11 P.M. indicated Resident 33 had two episodes of smacking herself when she did not get a desired answer, and continued to curse at staff. No intervention for the behavior was documented. A nursing note on 7/23/25 at 12:37 P.M., indicated Resident 33 remained fixated on wanting to be with spouse, was anxious about going home, continued to smack herself, and continued to curse and yell at staff. No intervention for the behavior was documented. A nursing note on 7/23/25 at 12:56 P.M., indicated Resident 33 had refused a weekly skin assessment. A nursing note on 7/23/25 at 2:22 P.M. indicated the NP was notified of resident's continued fixations and self harm. A new order was received to increase Risperdal to 1mg daily. During an interview on 8/18/25 at 9:48 A.M., Licensed Practical Nurse (LPN) 5 indicated prior to starting Resident 33 on Risperdal, non-pharmacological interventions included engaging in activities, assessing for pain or constipation, sensory activities, 1:1 with resident, and walks, and should have been documented in the clinical record. She indicated the resident had been started on Risperdal due to anxiety, agitation, and the previous antipsychotic had been ineffective. During an interview on (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/19/25 at 9:39 A.M., Resident 33's daughter indicated the resident had been taking Rexulti for about three months prior to her admission to the facility. During an interview on 8/19/25 at 8:44 A.M., a facility pharmacy representative indicated while there was no good conversion dose from Rexulti to Risperdal, Rexulti should have been immediately discontinued when starting Risperdal due to an increased risk of seizures when given together. On 8/20/25 at 11:29 P.M., the Administrator provided a current Use of Chemical Restraints policy, dated 5/11/16, that indicated Medication use is not the sole approach for behavioral intervention . Each resident's drug regimen must be free from unnecessary drugs 3.1-48(a)