

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Silver Oaks Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2011 Chapa Street Columbus, IN 47203	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>38769</p> <p>Based on observation, interview, and record review, the facility failed to identify a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident D)</p> <p>Findings include:</p> <p>During an observation on 02/13/24 at 2:50 P.M., RN 2 alerted Resident D of the need to observe his feet. The resident agreed and the resident's feet were observed with no concerns. After the resident was settled back into his chair he asked if she would like to look at his bottom. He indicated he had sores on his bottom that had been there for a while, they were sore, and he did not have them when he admitted to the facility. The resident's bottom was observed, there was no dressing in place and the following was observed:</p> <ul style="list-style-type: none"> - a small open area to the coccyx the size of a pencil eraser, the wound bed was pink in color with no drainage, - a small area to the left buttock cheek the size of a pencil eraser, the wound bed was pink in color with no drainage, and - a small area to the right buttock cheek the size of a pencil eraser, the wound bed was pink in color with no drainage. <p>During an interview on 02/13/24 at 2:54 P.M., RN 2 indicated the nurse had removed the dressing earlier in the day due to the resident having increased bowel movements. She had alerted her to replace it later when the resident's bowel movements were decreased.</p> <p>During an interview on 02/13/24 at 3:00 P.M., QMA (Qualified Medication Aide) 3 indicated she and the CNA (Certified Nurse Aide) that was working with her had never worked with the resident. They were unaware if the resident had wounds to his buttocks.</p> <p>The clinical record was reviewed on 02/13/24 at 1:15 P.M. An Admission MDS (Minimum Data Set) assessment, dated 02/01/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, hyponatremia, and respiratory failure. The resident was at risk for pressure ulcers and had no pressure ulcers at the time of admission. The resident was always incontinent of bowel and bladder.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Admission Observation and Data Collection record, dated 01/28/24, indicated the resident's Braden Scale for pressure ulcer predictability rated the resident as being at high risk.</p> <p>An Interdisciplinary Team (IDT) Progress Note, dated 01/29/23 at 3:07 P.M., indicated they had reviewed a bruising and wound event. The resident had scattered bruises to the bilateral upper extremities, a 3 cm (centimeters) x (by) 1 cm x 0.1 cm area on his spine, a 1 cm x 0.3 cm x 0.1 cm area on the slight left of the coccyx, and a 3 cm x 4 cm x 0.1 cm abscess on the anterior scrotum with yellow drainage. The bilateral feet had hardened, dark calluses at the sesamoid bone area on the bottom of the foot. The bilateral lower extremities were extremely dry. The resident and Nurse Practitioner were aware, and orders were in place. The resident would be monitored weekly on wound rounds.</p> <p>An open-ended physician's order, with a start date of 01/29/24, indicated the staff were to apply a foam dressing to the mid-spine and coccyx. The dressing was to be changed every 5 days and as needed for soilage.</p> <p>An open-ended physician's order, with a start date of 01/29/24, indicated the staff were to observe the dressing to the mid-spine and coccyx every shift, three times a day. The dressing may be peeled back so the area could be viewed to monitor for any open areas.</p> <p>A Progress Note, dated 02/04/24 at 5:24 A.M., indicated the resident's dressings had been changed to his scrotum, spine, and coccyx on Saturday night (02/03/24).</p> <p>A Point of Care History for skin problems for February 2024 indicated the resident had clear skin (without impairment) or a dressing on the following dates and times:</p> <ul style="list-style-type: none"> - 02/13/24 at 7:53 A.M., the residents' skin was clear and signed by RN 4 and QMA 6, - 02/12/24 at 12:18 A.M., the resident had a dressing in place to the back and buttocks and signed by RN 5, - 02/12/24 at 7:28 A.M., the residents' skin was clear and signed by CNA 7, - 02/12/24 at 11:52 A.M., the residents' skin was clear and signed by QMA 8, - 02/10/24 at 11:46 A.M., the residents' skin was clear and signed by QMA 8, - 02/09/24 at 7:24 A.M., the resident skin was clear and signed by CNA 7, - 02/08/24 at 10:27 A.M., the residents' skin was clear and signed by QMA 6, - 02/07/24 at 12:26 P.M., the resident's skin was clear and signed by QMA 6, - 02/06/24 at 1:02 A.M., 7:03 A.M., and 11:23 P.M., the resident's skin was clear and signed by QMA 8 and CNA 7, - 02/05/24 at 12:36 A.M., 6:43 A.M., and 3:03 P.M., the resident's skin was clear and signed by CNA 9, CNA 7, and CNA 10, <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 02/04/24 at 12:38 A.M., 7:53 A.M., and 3:49 P.M., the resident's skin was clear and signed by CNA 9, RN 11, and QMA 6,</p> <p>- 02/03/24 at 6:59 A.M., the resident's skin was clear and signed by CNA 7</p> <p>- 02/02/24 at 6:55 A.M., 4:07 P.M., and 11:18 P.M., the resident's skin was clear and signed by CNA 7, QMA 6, and CNA 9, and</p> <p>- 02/01/24 at 6:55 A.M., the resident's skin was clear and signed by CNA 7.</p> <p>The clinical record lacked indication the resident had any pressure ulcers to the coccyx.</p> <p>During an interview on 02/13/24 at 3:05 P.M., Wound Care Nurse 12 indicated the resident came to the facility with an abscess to his scrotum, a bruise to the spine, and a bruise to the coccyx. When a resident was admitted to the facility, she would look through the hospital documentation and complete an assessment to determine if there were any skin issues. If a resident acquired a new skin issue while in the facility she would rely on the nurses and aides to let her know about it. The nurses would then open an event to monitor the area. The staff should be alerting her if the resident had any new reddened areas, non-blanchable areas, or any type of skin breakdown.</p> <p>During an observation and interview on 02/13/24 at 3:15 P.M., Resident D's coccyx was reviewed with Wound Care Nurse 12. She indicated the resident had a small Stage 2 to the sacrum that measure 0.5 cm x 0.5 cm with excoriation to the bilateral buttocks, the wounds did not have any drainage. The staff should have let her know of the resident's condition of his bottom before the areas were open as they were able to remove the dressing to look at the bottom. The areas were not there on admission.</p> <p>The current facility policy titled, 'GUIDELINES FOR WEEKLY SKIN OBSERVATION', with a review date of 12/31/23, was provided by Clinical Support on 02/13/24 at 4:05 P.M. The policy indicated, 'To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated. In addition to the Weekly Observation by the licensed nurse, the nurses assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified.'</p> <p>This citation relates to Complaint IN00426993.</p> <p>3.1-40(a)(2)</p>		