STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Oaks Health Campus	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38769 Based on record review and interview, the facility failed to provide bathing for 2 of 3 dependent residents reviewed for Activities of Daily Living. (Residents C and D) Findings include: 1. During an interview on 05/06/24 at 2:34 P.M., QMA (Qualified Medication Aide) 10 indicated residents were to be offered showers at least twice a week but could have more if requested. The showers were given on dayshift and evening shift. The bathing was to be documented in the electronic record and they were to fill out a skin sheet on each resident after bathing. The skin sheets were signed by the nurse and then given to the ADON (Assistant Director of Nursing). During an interview on 05/06/24 at 2:50 P.M., CNA Student (Certified Nurse Aide Student) 8 indicated If a resident refused a shower, she would offer to give them a bed bath and document the refusal of bathing or the type of bathing in the computer charting. The clinical record for Resident C was reviewed on 05/02/24 at 3:02 P.M. An Admission MDS (Minimum Data Set) assessment, dated 04/03/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, hypertension, heart failure, diabetes, malnutrition, anxiety, and depression. The Point of Care History and the Shower Sheets indicated the resident had the following showers or complete bed baths since admission to the facility on [DATE]: - 04/03/24, shower, - 04/06/24, complete bed bath, - 04/13/24, shower, - 05/01/24, shower, - 05/04/24, refused, and - 05/05/24, complete bed bath. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had only received 6 of 20 scheduled showers or complete bed baths since admission. There was only one documented resident refusal of a scheduled shower or complete bed bath. 2. The clinical record for Resident D was reviewed on 05/06/24 at 9:38 A.M. An Admission MDS assessment, dated 03/04/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, anemia, diabetes, and malnutrition. The Point of Care History and the Shower Sheets indicated the resident had the following showers/bathing from admission to the facility on [DATE] until discharge on [DATE]: - 02/28/24, shower, - 03/08/24, shower, - 03/11/24, shower, - 03/13/24, shower, - 03/18/24, shower, - 03/23/24, lack of documentation of a bathing, the skin sheet indicated the resident had no new skin concerns with no documentation of shower and the point of care history indicated no bathing occurred, and - 03/29/24, shower. The resident had 7 of 11 showers, complete bed baths, or refusals documented in the clinical health record. The current facility policy, titled Guidelines for Bathing Preference with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, .Bathing shall occur at least twice a week unless resident preference states otherwise . The current facility policy, titled Nursing ADL [activities of daily living] Documentation Guidelines with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, To document the type and amount of assistance provided to the resident for activities of daily living .Completion of ADL service will be validated through the use of the CARE ASSIST ADL reports .ADL services will be conducted and documented by the CNA each shift at the [point of care] or as reasonably possible after care . This citation relates to Complaint IN00432712. 3.1-38(a)(2)(A)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33613 Based on interview, observation, and record review, the facility failed to hold a resident's blood pressure medication when vitals were outside of the physician's hold parameters for 1 of 16 residents reviewed for quality of care. (Resident E) Findings include: The clinical record for Resident E was reviewed on 05/02/24 at 10:10 A.M. An Admission Minimum Data Set assessment, dated 03/06/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, senile degeneration of the brain, anemia, diabetes, heart failure, and hypertension. A current physician's order, with a start date of 02/28/24, indicated the resident was to get metoprolol succinate (a blood pressure medication) extended release 24 hour tablet, 100 mg (milligrams), one time a day, for hypertension. The staff were to hold the medication if the resident's heart rate was less than 60. The March and April 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident received the medication when the heart rate was less than 60 on the following dates: - On 03/05/24, the resident's heart rate was 55. - On 03/07/24, the resident's heart rate was 57. - On 03/08/24, the resident's heart rate was 52. - On 03/09/24, the resident's heart rate was 55. - On 03/10/24, the resident's heart rate was 56. - On 03/14/24, the resident's heart rate was 51. - On 03/16/24, the resident's heart rate was 55. - On 03/24/24, the resident's heart rate was 47. - On 03/26/24, the resident's heart rate was 55. - On 04/04/24, the resident's heart rate was 45. - On 04/10/24, the resident's heart rate was 53. - On 04/17/24, the resident's heart rate was 59. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 04/22/24, the resident's heart rate was 51. - On 04/30/24, the resident's heart rate was 49. During an interview on 05/08/24 at 2:49 P.M., Licensure Practical Nurse (LPN) 5 indicated if a resident's medication had hold parameters for the heart rate, the heart rate should be obtained prior to the medication being given. If the heart rate was outside of the parameters, the medication shouldn't be administered, and the Nurse Practitioner should be notified. The current facility policy titled, Medication Administration-General Guidelines with a revised date of 11/18, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, .Medications are administered in accordance with the written orders of the prescriber . This citation relates to Complaint IN00433027. 3.1-40(a)(1) 3.1-40(a)(2) 3.1-37(a)

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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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. 33613 Based on interview, observation, and record review, the facility failed to ensure a resident did not acquire a burn during care. This deficient practice resulted in Resident B sustaining a second-degree burn (a mild to moderate burn caused by heat, chemical, or light source and damages the outer and second layer of skin) on the left foot. (Resident B) Findings include: An Annual MDS (Minimum Data Set) assessment, dated 02/08/24, indicated Resident B was cognitively intact. The diagnoses included, but were not limited to, traumatic spinal cord dysfunction, quadriplegia, hypertension, and neurogenic bladder. The resident required extensive staff assistance with all ADL (Activities of Daily Living). The resident's clinical record lacked documentation of an order, or a care plan related to the staffs' use of a blow dryer to dry the resident's feet. A Progress Note, dated 04/02/2024 at 5:45 P.M., indicated the resident requested for CNA 2 to dry her feet with a blow dryer. CNA 2 dried the resident's feet and now there was redness observed to the resident's left foot. A cool rag was placed on the resident's foot and LPN 3 was monitoring the resident's condition. A Progress Note, dated 04/03/2024 at 12:49 P.M., indicated the resident had blisters present to the top of her left foot toe areas. A new order was entered by the NP to leave the blisters open to the air. A Progress Note, dated 04/04/2024 at 8:50 A.M., indicated the resident was seen by the NP (Nurse Practitioner) and presented with fluid filled blisters to the top of the left foot. The resident had requested for staff to blow dry her feet after her shower. After the CNA dried the resident's feet the resident had redness to her foot and later blisters appeared on her toes. A topical cream was ordered for the blisters. A Wound Center Note, dated 04/10/24, indicated the resident was being seen for second degree burns on the left 1st through 4th toes. During an interview on 04/30/24 at 10:10 A.M., Resident B indicated her shower days were Tuesday and Friday. She had been having her feet dried with the blow dryer for a long time, since it was recommended by her podiatrist. On 04/02/24, after her shower she had asked CNA (Certified Nurse Aide) 2 to dry her feet with the blow dryer. This was the first time CNA 2 had assisted her with her shower. The resident had looked down at her left foot and it was red. She had brought this to the attention of CNA 2. The CNA seemed to not be paying attention. The resident was unable to feel her feet. CNA 2 then informed LPN (Licensed Practical Nurse) 3 of the resident's red foot. The LPN advised the DON (Director of Nursing). Blisters had formed on the resident's toes later that evening. The resident went to the wound center for treatment for the blisters on the toes of the left foot. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	During an observation 04/30/24 at 10:35 A.M., RN 11 removed the gauze dressing from Resident B's left foot. Each of the resident's 5 toes had a dried opened blister. The toes were cleaned with normal saline, patted dry, coated with a liquid antiseptic, gauze was placed between each toe, and the entire foot was wrapped with gauze and secured with tape. During an interview on 05/06/24 at 10:45 A.M., CNA 4 indicated Resident B required total assistance with all ADLs. She received her showers on second shift on Tuesdays and Fridays. The CNAs were aware the resident wanted her feet dried with a blow dryer. During an interview on 05/06/24 at 11:03 A.M., CNA 2 indicated she had not assisted Resident B in the shower prior to the incident with the blow dryer and had not been trained on using a blow dryer on the resident's feet. The resident requested she use the blow dryer to dry her feet. Her foot wasn't red until she finished drying them. When she noticed the resident's foot was red, she notified LPN 3. During an interview on 05/06/24 at 2:01 P.M., LPN 3 indicated CNA 2 asked him to assess the foot of Resident B after her shower. The foot was more red than normal. He notified the DON of the situation, and she came to assess the left foot. He didn't think CNA 2 was aware the resident didn't have feeling in her feet. During an interview on 05/08/24 at 2:13 P.M., the NP indicated the resident had requested the CNA to blow dry her feet when she was finished with her shower. She gave an order to treat the burns at the time of the occurrence. She wasn't sure the CNA was aware the resident didn't have feeling in her feet. The current facility policy titled, Notification of Change in Condition with a revised date of 12/31/23, was provided by the Administrator on 05/08/24 at 3:23 P.M. The policy indicated, .To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician .when .An accident involving the resident which results in an injury and has the potential for requiring physician intervention . Brain and Spinal Cord Injury information at www.brainandspinalcord.org/quadriplegia .Related injuries. People with quadriplegia may experience an injury, such as a burn, without realizing it, since they have no sensation in their limbs. For this reason, it is important that your caregivers do not place a heating pad or electric blanket on you . Indiana_Nurse_Aide_Curriculum.pdf, Pages 22 through 29 .IV.Burns .Risk Factors .1 .paralysis .3.Heating appliances .BPrevention .1.know residents that are at risk .2.Check/report use of heating appliances . The Past noncompliance began on 04/02/24 and the deficient practice was corrected prior to the start of the survey. On 04/04/24, the facility implemented a systemic plan that included the following actions: The facility completed education on impaired sensation and the use of blow dryers for all staff members. This citation relates to complaints IN00431864 and IN00430897. 3.1-47(a)(7)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 38769 Based on observation, interview, and record review, the facility failed to follow a resident's diet order for 1 of 2 residents reviewed for therapeutic diets. (Resident C) Findings include: During a continuous observation and interviews on 04/29/24 from 12:16 P.M. through 12:29 P.M., the following was observed in the 600 Hall dining room: - At 12:16 P.M., Resident C was sitting at a dining room table, waiting for lunch, - At 12:20 P.M., Resident C was served a lunch plate that contained a slice of ham, cheddar hashbrowns, roasted carrots, and a piece of cake, RN 6 went and cut up the resident's ham into bite size squares. The resident's meal ticket sitting on the table in front of her indicated she was a mechanical soft diet, - At 12:25 P.M., RN 6 indicated the resident's diet orders were in the electronic record. When the resident had a new diet order it would get sent to the kitchen and printed on their meal ticket. The staff should follow the meal ticket. Resident C used to be on a mechanical soft diet, but it had recently changed but the kitchen hadn't updated her meal ticket, she confirmed the meal ticket indicated mechanical soft. She confirmed the resident order in the clinical record was started on 04/10/24 as a mechanical soft diet and indicated she should have been served a mechanical soft diet until the order changed. She would have to confirm with the Speech Therapist about the resident's diet, -At 12:27 P.M., the Speech Therapist indicated the resident was to be on a mechanical soft diet and should have been served a mechanical soft meal. She went and observed the resident and ordered a mechanical soft diet from the kitchen, -At 12:29 P.M., the Dietary Manager indicated the cook working in the 600 Hall kitchen had never worked down there before. The resident's all had meal trays that indicated what their diet was, and the kitchen and other staff should follow the diet order. The meal tickets would be updated if the order changed. The aides should be looking at the tickets when serving the meals to ensure the meal served is the correct diet. If the meal was incorrect, they would give it back to the cook to get the correct diet. The resident's diet order was reviewed on 04/29/24 at 12:25 P.M. The open ended, diet order with a start date of 04/10/24, indicated the resident was to be on a mechanical soft diet with extra gravy and no straws. An Admission MDS (Minimum Data Set) assessment, dated 04/03/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, metabolic encephalopathy, hypertension, heart failure, diabetes, malnutrition, anxiety, and depression. The resident had episodes coughing or choking during meals or when swallowing medications and had complaints of difficulty or pain with swallowing and had no natural teeth. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident did not have any documented concerns related to coughing or choking after the admission assessment. The current facility policy titled, Resident Dining & Nutritional Preferences with an approval date of January 2024, was provided by the DON (Director of Nursing) on 05/06/24 at 2:41 P.M. The policy indicated, .The Dining Services and Clinical Nutrition Support teams have continued commitment to ensuring our residents have the best dining experience possible .The dietary order is included in the 48-hour baseline care plan . The individual resident's food plan meets his or her nutritional needs . 3.1-46(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38769 Based on observation, record review, and interview, the facility failed to follow physician orders related to a blood thinner for 1 of 6 resident reviewed for pharmacy services. (Resident 219) Findings include: During an observation on 05/01/24 at 2:20 P.M. Resident 219 was lying in his bed. His call light was in reach, and he said he was feeling good that day with no concerns. The resident had no visible bruises or bleeding. The clinical record for the resident was reviewed on 05/06/24 at 12:13 P.M. An Admission MDS (Minimum Data Set) assessment, dated 04/19/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture, anemia, atrial fibrillation, and hypertension. The resident had received an anticoagulant while in the facility. A Progress Note, dated 04/24/24 at 4:01 P.M., indicated a new order was received to give Coumadin 7 mg daily and recheck the PT/INR (Prothrombin Time/International Normalized Ratio) on 04/26/24. A Progress Note, dated 04/26/24 at 12:57 P.M., indicated a new order was received to continue Coumadin 7 mg daily and recheck PT/INR on 04/29/24. A Progress Note, dated 04/29/24 at 12:55 P.M., indicated a new order was received to start Coumadin 2 mg on Sunday, Monday, Wednesday, and Friday. Give 3 mg on Tuesday, Thursday, and Saturday. A physician's order, dated 04/24/24 through 04/29/24, indicated the resident was to receive Warfarin (Coumadin), a 5 mg with the 2 mg tablet to equal 7 mg, once a day. A physician's order, dated 04/24/24 through 04/26/24, indicated the resident was to receive Warfarin, a 2 mg, with the 5 mg tablet to equal 7 mg, once a day. The April EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident lacked receiving the Coumadin dose 2 mg from 04/26/24 through 04/28/24. During an interview on 05/06/24 at 2:40 P.M., RN 6 indicated when a resident had orders for PT/INR's they were completed first thing in the morning. The night shift nurse would obtain the results and send them to the physician. The day shift nurse would then coordinate with the physician if the dose needed to be changed or remained the same. The nurse working the floor, or the physician could input the resident's orders. During an interview on 05/08/24 at 11:15 A.M., the DON (Director of Nursing) indicated she was unsure why the resident's 2 mg dose of Coumadin had discontinued on 04/26/24 when the order was to remain the same. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled, Medication Administration-General Guidelines with a revised date of 11/18 was provided by the DON on 05/08/24 at 9:55 A.M. The policy indicated, .Medications are administered as prescribed in accordance with good nursing principals and only by persons legally authorized to do so . 3.1-37(a)