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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155289 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/03/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL OAKS HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4725 S COLONIAL OAKS DR<br>MARION, IN 46953 |
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| F 000<br><br>Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00167998.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00167998 - Substantiated, Federal/State deficiency related to the allegations is cited at F 314.</p> <p>Survey dates: February 25, 26, 27, 2015 through March 2 and 3, 2015</p> <p>Facility Number: 000186<br/>Provider Number: 155289<br/>AIM Number: 100266300</p> <p>Survey Team:<br/>Tina Smith-Staats, RN, TC<br/>Karen Lewis, RN<br/>Ginger McNamee, RN<br/>Toni Maley, BSW<br/>Winter Hyde, RN (February 25, 26, 27, 2015)</p> <p>Census Bed Type:<br/>SNF/NF: 103<br/>Total: 103</p> | F 000 |  |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

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| F 314<br>SS=D<br>Bldg. 00 | <p>Census Payor Type:<br/>Medicare: 20<br/>Medicaid: 64<br/>Other: 19<br/>Total: 103</p> <p>This deficiency also reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 6, 2015 by Randy Fry RN.</p> <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br/>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p> |               |   |                      |

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|                    | <p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to provide care and services to promote the healing of pressure ulcers, and failed to provide interventions to prevent the development of pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. (Residents #C, #D, and #B)</p> <p>Findings include:</p> <p>1. The following observations for Resident #C were made on 2/27/15:</p> <p>At 8:43 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the hallway;</p> <p>At 8:49 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the doorway, and her eyes were open;</p> <p>At 9:36 a.m., the resident was sitting in a broda chair with the chair back upright</p> | F 314         | <p>The facility is unable to correct the alleged deficient practice for residents #C, D and B.All residents have the potential to be affected by the alleged deficient practice.Nursing will audit the care plans for all residents with any current pressure areas and/or the potential of developing a pressure area will be reviewed to ensure the appropriate interventions are in place. DON/Designee to review the results of audit conducted. All residents in Broda chairs or residents with current skin issues will be toileted/checked and/or changed after the morning meal and placed back to bed after lunch. Rounds checklist will include placement of wheelchair cushions for all residents. DON/Designee to in-service the Nursing staff regarding turning and repositioning residents, additional pressure ulcer preventions and will review the rounds checklist each business day for any concerns.QA Committee to review the results of the audits monthly ongoing.</p> | 04/02/2015           |

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|                    | <p>and her legs raised approximately 25 degrees, in her room facing the hallway;</p> <p>At 9:53 a.m., the resident was sitting in a broda chair with back upright and her legs raised approximately 25 degrees, in her room facing the doorway;</p> <p>At 10:22 a.m., the resident was in her bed, resting on her back with a bowel movement odor noted in the room;</p> <p>And at 11: 07 a.m., the resident was in her bed, resting on her back.</p> <p>The following observations for Resident #C were made on 3/2/15:</p> <p>At 8:33 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the dining room;</p> <p>At 8:38 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the dining room;</p> <p>At 8:40 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television;</p> <p>At 9:28 a.m., the resident was sitting in a</p> |               |   |                      |

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|                    | <p>broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes closed;</p> <p>At 9:43 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, LPN #9 entered the room and rearranged the resident's blanket and left the room;</p> <p>At 10:00 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 10:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes closed;</p> <p>At 11:08 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes closed;</p> <p>At 11:14 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> |               |   |                      |

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|                    | <p>At 11:25 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes open;</p> <p>At 11:30 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the activity room, no staff were present;</p> <p>At 12:28 p.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television;</p> <p>At 1:39 p.m., the resident was in bed, resting on her back, with her eyes closed;</p> <p>At 1:47 p.m., the resident was in bed, resting on her back, with her eyes closed;</p> <p>At 1:53 p.m., observed wound care for Resident #C;</p> <p>And at 2:58 p.m., the resident was in bed, resting on her back, with her eyes closed.</p> <p>The resident was not repositioned during any of the observations on 3/2/15 from 8:33 a.m. through 12:28 p.m.</p> |               |   |                      |

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|                    | <p>The following observations of Resident #C were made on 3/3/15:</p> <p>At 7:37 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room with a baby doll in her lap, her eyes were closed and the chair was angled toward the foot of the bed;</p> <p>At 8:40 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television with her eyes open;</p> <p>At 8:48 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 8:51 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes closed;</p> <p>At 9:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> |               |   |                      |

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|                    | <p>At 9:35 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 9:41 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 10:20 a.m., the resident was sitting in a broda chair with the back upright and the legs raised approximately 25 degrees, in her room facing the television, her eyes were closed and the hospice nurse entered the room;</p> <p>At 10:50 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room with her eyes closed;</p> <p>And at 11:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed.</p> <p>The resident was not repositioned during any of the observations on 3/3/15 from 7:37 a.m. through 11:11 a.m.</p> |               |   |                      |

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|                    | <p>The clinical record for Resident #C was reviewed on 3/2/15 at 1:20 p.m. Diagnoses for Resident #C included, but were not limited to, Alzheimer's disease, muscle weakness, and abnormal posture. Resident #C was admitted to hospice on 1/17/15.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 1/29/15, indicated Resident #C could not complete a mental status interview because she was rarely or never understood. The assessment indicated Resident #C had an altered level of consciousness which fluctuated (comes and goes, and changes in severity) and psychomotor retardation which fluctuated also. The assessment indicated Resident #C required total assistance from the staff for all turning and repositioning services. The assessment indicated the resident was at risk of developing pressure ulcers.</p> <p>An "Initial Pressure Ulcer Report", dated 2/16/15, indicated Resident #C had a stage 2 pressure ulcer, defined as "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough", on her left buttock. The area measured 1.8 centimeters (cm) by 2.0 cm with "wound edges well defined and attached."</p> |               |   |                      |

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|                    | <p>A "Pressure Ulcer Progress Report", dated 2/23/15, indicated Resident #C had a stage 2 pressure ulcer on her left buttock. The area measured 1.8 cm by 2.0 cm with "wound edges well defined and attached." A stage 2 pressure ulcer on her coccyx. The area measured 0.8 cm by 0.2 cm with "wound edges well defined and attached." An unstageable pressure ulcer, defined as "full tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed", on her right buttock. The area measured 0.8 cm by 1.2 cm with "no open areas noted." One of the preventative devices checked as being used for the resident was "turning/positioning program."</p> <p>Resident #C had a health care plan focus of a stage 2 pressure ulcer on left buttock and coccyx, initiated on 2/16/15 and revised on 2/23/15. Interventions for this focus included, but were not limited to, turn and reposition every two hours and more frequently as needed, and toilet according to the toileting program.</p> <p>Resident #C had a health care plan focus of an unstageable pressure ulcer on right buttock, initiated on 2/23/15. The health care plan lacked any interventions related to turning and repositioning the resident.</p> |               |   |                      |

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|                    | <p>During an interview on 3/3/15 at 10:44 a.m., CNA #6 indicated she did not know why Resident #C was still in her chair and had not returned to bed after breakfast.</p> <p>During an interview on 3/3/15 at 10:54 a.m., CNA #7 indicated she works the day shift and her shift begins at 6:00 a.m. She indicated Resident #C is up in her chair when she arrives to work. CNA #7 indicated Resident #C should be transferred back to bed after breakfast. She indicated Resident #C requires the use of a Hoyer lift to be transferred and two staff are required to use the lift. CNA #7 indicated if a resident has skin issues with his or her bottom, then the resident should not be up in a chair for more than two hours at a time. CNA #7 indicated staffing for the facility is based on the number of residents and not the difficulty in the care for each resident. CNA #7 indicated it is sometimes difficult to get the residents back in bed or repositioned as they should be. CNA #7 indicated there are usually two CNAs and one nurse working on Hickory Hall and two CNAs and one nurse working on Redbud Court.</p> <p>During an interview on 3/3/15 at 11:20 a.m., CNA #8 indicated Resident #C</p> |               |   |                      |

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|                    | <p>requires total assistance and use of the Hoyer lift for transfers. CNA #8 indicated two staff are required when using the Hoyer lift. CNA #8 indicated if a resident has skin concerns with his or her bottom, the resident should only be up in a chair for "just a couple of hours."</p> <p>During an interview on 3/3/15 at 1:03 p.m., LPN #9 indicated Resident #C gets up in the morning between 5:00 a.m. and 6:00 a.m. LPN #9 indicated Resident #C can be repositioned in her chair but should go back to bed after breakfast. LPN #9 indicated they try to get everything done for the residents. LPN #9 indicated Hickory Hall and Redbud Court need 6 staff but they are lucky when they have 5 staff. LPN #9 indicated the extra CNA is "split" between the two halls.</p> <p>During an interview on 3/3/15 at 1:10 p.m., LPN #10 indicated when there are five staff for Hickory Hall and Redbud Court "things go well", and tasks are able to be completed.</p> <p>During an interview on 3/3/15 at 1:58 p.m., Unit Manager #11 indicated Resident #C can be repositioned in her chair by tilting the chair back and adjusting the legs. She indicated she tries to check on all the residents in broda</p> |               |   |                      |

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|                    | <p>chairs after the weekday morning meeting. She indicated she thought the residents had been getting turned and repositioned as needed.</p> <p>2. Resident #B's clinical record was reviewed on 2/27/15 at 11:31 a.m. The resident's diagnoses included, but were not limited to, anxiety, depressive disorder, congestive heart failure, and chronic bronchitis.</p> <p>An Initial Pressure Ulcer report dated 1/28/15, indicated a pressure area, located on the left buttock, was not present upon admission. The pressure area was first noted on 1/28/15. The measurement of the pressure area located on the left buttock was 4.5 cm x 1.5 cm. The pressure area was staged as a stage II pressure ulcer with no drainage or odor. The periwound area was documented as normal in color. The documented treatment ordered was to cleanse with wound cleanser, apply skin prep to periwound skin, cover with Duoderm extra thin, change every 3 days and as needed.</p> <p>Resident #B had a skin care order dated 1/28/15. The order stated: "Skin care to upper buttocks: cleanse with wound cleanser or mild soap and water, pat dry. Apply Nystatin powder between upper cheeks of buttocks two times a day for</p> |               |   |                      |

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|                    | <p>irritated skin."</p> <p>Resident #B had an skin care order dated 1/28/15. The order stated: "Wound care left buttocks [sic]: cleanse wound with wound cleanser, apply skin prep to periwound edges, cover with Duoderm extra thin, change every 3 days and as needed."</p> <p>During an observation on 3/2/15 at 2:13 p.m., the Assistant Director of Nursing (ADON) entered the room of Resident #B and put on a pair of gloves and assembled the wound care supplies at the bedside. The ADON then assisted the resident in repositioning onto the right side and adjusted the resident's clothing and exposed the resident's buttocks. The ADON explained that Resident #B had two areas that would be receiving treatment. Resident #B had an order for Nystatin to be used on the skin between the left and right buttocks. She cleaned the area with wound cleanser and patted it dry with a 4 x 4 gauze. The ADON then sprinkled the Nystatin powder onto a new 4 x 4 gauze. She shook the powder over an opened soda pop can located on the bedside table. The ADON did not remove her gloves nor did she wash her hands. The ADON assessed the wound. The ADON went back to the treatment cart to retrieve more dressing supplies.</p> |               |   |                      |

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|                          | <p>She brought them back to the bedside, then removed her gloves and washed her hands. The ADON then put on a new pair of gloves. The wound was measured and the measurements were written on the back of the paper measuring tape, that had been used to measure the wound, with an ink pen she removed from her hair. The ADON then placed the ink pen back in her hair. The ADON then applied the new dressing to the wound area. The ADON then placed Nystatin back into the plastic bag while still wearing the gloves she wore while dressing the wound. The ADON then removed her gloves and washed her hands. She picked up the trash and dressing change supplies and took them back to the treatment cart. The trash was discarded in the trash container located on the side of the treatment cart and the supplies and Nystatin were placed inside the treatment cart.</p> <p>A current facility policy dated 6/20/12, titled "Clean Dressing Change" was provided by the Unit Manager #1 on 3/3/15 at 10:30 a.m., and indicated the following:<br/>"Purpose:<br/>1. To protect the wound from contamination.<br/>2. To absorb drainage.<br/>3. To promote a healing environment.</p> |                     |  |                            |

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|  | <p>...General Guidelines:</p> <ol style="list-style-type: none"> <li>1. Bring all equipment to the bedside within easy reach.</li> <li>...4. Perform hand hygiene and put on gloves.</li> <li>5. Remove the soiled dressing and pull soiled gloves off over dressings and dispose of in moisture-proof bag.</li> <li>6. Perform hand hygiene and put on clean gloves.</li> <li>7. Cleanse the wound with prescribed solution. The wound is cleaned from top to the bottom or with outward strokes from the least contaminated to the most contaminated. For irregular wounds, such as decubitus, clean from the center outward using circular strokes.</li> <li>8. Remove soiled gloves and Observe [sic] the overall appearance of the wound.</li> <li>...11. Dispose of trash and clean hands ..."</li> </ol> <p>A current facility policy dated 4/2012, titled "Hand Washing" was provided by the Unit Manager #1 on 3/3/15 at 10:30 a.m., and indicated the following:<br/>"Policy: To Ensure [sic] proper hand washing before and after procedures and/or resident care to prevent the spread of infection.<br/>...When to Wash Hands (at a minimum):<br/>Before putting on and after taking off gloves.</p> |   |   |                      |   |

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|                    | <p>When reporting to work or going home.<br/>Before eating and drinking.<br/>Before and after using toilet.<br/>After sneezing, coughing, or blowing nose.<br/>After touching hair, face, clothing etc.<br/>After smoking cigarettes.<br/>Before and after each resident contact.<br/>After touching resident or handling his or her belongings.<br/>Whenever hands are visibly soiled.<br/>After contact with any body fluids.<br/>After handling any contaminated items (linens, soiled briefs, garbage, etc."3.<br/>Resident #D was observed on 3/2/15 at 9:47 a.m., up in a wheelchair being pushed by a CNA. The resident did not have a cushion in his wheelchair. He was sitting on a white folded incontinent pad.</p> <p>Resident #D was observed in activities on 3/2/15 at 10:58 a.m. He was sitting in his wheelchair on a white folded incontinent pad with no cushion.</p> <p>Resident #D was observed in his room on 3/2/15 at 11:33 a.m. He was sitting in his wheelchair with no cushion in the chair.</p> <p>Resident #D was observed in bed on 3/2/15 at 1:52 p.m. There was no wheelchair cushion observed in the room.</p> <p>An observation of the resident's treatment</p> |               |   |                      |

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|                    | <p>to the left buttock was made on 3/2/15 at 2:35 p.m., with the Assistant Director of Nursing and CNA #2 present. No cushion for the wheelchair was observed. CNA #2 indicated the resident was suppose to have a cushion in his wheelchair. The CNA indicated the wheelchair had been washed the night before and the cover to the cushion had probably been removed for cleaning. The CNA indicated the cushion cover needed to be air dried and it takes longer to dry thoroughly. The Assistant Director of Nursing indicated the resident should have a cushion in his wheelchair. She indicated extra cushions were available and she would have replaced the cushion if staff had informed her.</p> <p>Resident #D's clinical record was reviewed on 2/27/15 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dysphagia and cognitive deficits due to cerebrovascular disease, osteoarthritis, peripheral neuropathy and Stage II chronic kidney disease.</p> <p>The resident had a 2/22/15, physician's order to cleanse area to left buttock with dermal wound cleanser, apply aquacel ag [a topical wound medication], cover with duoderm thin, change dressing every other day and as needed till healed.</p> |               |   |                      |

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|                    | <p>The resident had a 1/2/15, quarterly Minimum Data Set assessment. The assessment indicated the resident required extensive one person physical assistance for bed mobility and transfers. The assessment indicated the resident was at risk for developing pressure ulcers.</p> <p>The resident had a 2/23/15, care plan focus for a suspected deep tissue injury on the left buttock related to extended pressure. An intervention for this problem was a cushion in the chair for pressure redistribution.</p> <p>A 2/22/15, "Initial Pressure Ulcer Report", indicated Resident #D had a 0.5 cm by 0.5 cm suspected deep tissue injury to the left buttock.</p> <p>4. The 10/10, revised "Wound Prevention Protocol" was provided on 3/3/15 at 2:30 p.m., by the RN Consultant. The purpose of the protocol was to: identify residents that were at high risk for developing pressure areas; to relieve or remove pressure to prevent tissue trauma; and to initiate nursing interventions along with medical orders to prevent tissue trauma. The protocol indicated chair bound residents at moderate and high risk for developing pressure areas were to be repositioned</p> |               |   |                      |

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|  | and encouraged to shift weight every<br>hour. Staff were to assist with<br>positioning as needed.<br><br>This Federal tag relates to complaint<br>IN00167998.<br><br>3.1-40(a)(1)<br>3.1-40(a)(2) |  |  |                            |  |