STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00370308. Complaint IN00370308 - Substantiated. Federal/state deficiency related to the allegations is cited at F686. Survey date: 1/10/2022 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 12 Medicaid: 13 Other: 3 Total: 28 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/13/22.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective January 28, 2022 to the complaint survey completed on January 10, 2022.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review, and interview, the facility failed to ensure pressure ulcer assessments were completed at least weekly to determine the healing status of the pressure ulcers. Two of the pressure ulcers deteriorated, a surgical debridement was completed, and new treatment orders were received for the deterioration of the pressure ulcers when assessed by the Wound Physician, for 2 of 3 residents reviewed for pressure ulcers. (Residents C & D) Findings include: 1) During an observation on 1/10/22 at 10:09 a.m. with RN 1, Resident C was lying in bed with her head of the bed elevated. There was a heel protector boot on the right heel. RN 1 indicated the facility Wound Nurse works part time and the Wound Physician consulted on the pressure ulcers weekly. RN 1 completed the treatment to the coccyx pressure ulcer. The dressing was removed from the coccyx and there was a scant amount of drainage. The wound was clean and beefy red. RN 1 measured the area as 4.2 cm (centimeters) by 5 cm and 1 cm depth. She then applied Dakin's solution (antiseptic) to a gauze, loosely packed the wound and covered the area with a dry dressing.	F 0686	**IDR info is in the attachments** **F686** **It is the practice of this facility to assure that the all residents receive the necessary care and services to prevent and treat pressure ulcers.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident C has been examined weekly with proper assessment including measurements. Resident D has been examined weekly with proper assessment including measurements ***Other residents that have the potential to be affected have been identified by:*** All residents that have been identified to have pressure ulcers are being assessed weekly by the wound nurse with proper assessment including measurements. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	01/28/2022

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	During an interview on 1/10/22 at 3:05 p.m., RN 1 indicated the wound treatment for the right heel was not scheduled to be completed until 1/11/22. Resident C's record was reviewed on 1/10/22 at 1:57 p.m. The diagnoses included, but were not limited to stroke. A Quarterly Minimum Data Set assessment (MDS), dated 12/22/21, indicated short and long term memory problems, extensive assistance with bed mobility and dependent for transfers. There was one stage two (partial thickness of skin loss) pressure ulcer present on admission, and one stage four (full thickness skin loss with extensive destruction, tissue necrosis or damage to the muscle bone, or supporting structures) pressure ulcer present. A Care Plan, dated 11/30/21, indicated pressure ulcers were present on the right heel and coccyx. On 12/7/21 a new pressure ulcer was present upon return from the hospital. The interventions included, a heel boot was to be used, air mattress for the bed, the Wound Physician was to be consulted, changes in the skin status were to be documented and reported to the physician as needed, which included appearance, color, wound healing, wound size and stage of the pressure ulcer. a. The Wound Evaluation Flow Sheet form, indicated a deep tissue injury (injury to underlying tissue below the skin's surface due to pressure) was found on the right heel on 11/3/21. The Right heel had been measured on 12/21/21, and was 1.1 cm by 1.5 cm, was 100% necrotic with no drainage, and the surface area measured 1.65 cm. The treatment to right heel was betadine daily		***include:*** In the event the wound nurse and/or wound doctor are unavailable for rounds, a designee will be appointed to complete assessments. This will include the DON, MDS Coordinator, and/or licensed staff. All nurses have been in-serviced related to assuring that all residents identified as having skin issues are to have weekly measurements as part of the assessment process. In addition, the inservice included that if the licensed nurse providing the treatment identifies any negative changes in the area being treated that they are to notify the wound nurse/physician for further assessment. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to observe to randomly observe 5 residents (if applicable) that have pressure ulcers to assure that the weekly assessment includes measurements. The Director of Nursing, or designee, will complete this audit weekly x3, then monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at least quarterly. ***The date the systemic changes***	

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	and leave open to the air. The Wound Physician's Progress Note, dated 12/21/21, indicated the right heel measurements were 1.1 cm by 1.5 cm , the surface area was 1.65, there was no drainage, the area was 100% necrotic, and there was no change in the wound progress. The treatment was to apply betadine daily to the area and leave open to the air. The area was not infected and debridement was needed. The Right heel was measured on 1/4/22 and was 2.5 cm by 3 cm, with 40% necrosis and 60% dermis. There was moderate serous drainage (clear and thin), the surface area was 7.50 cm, and the pressure ulcer had deteriorated. The Wound Physician's Progress Note, dated 1/4/22, indicated the right heel measurements were 2.5 cm by 3.0 cm and the depth could not be measured. The surface area was 7.5 cm, there was a moderate amount of serous drainage, and the thick adherent black necrotic tissue was 40% with 60% dermis. The wound had deteriorated and a surgical decisional debridement was completed to remove the thick eschar and necrotic tissue. 3 cm of devitalized tissue and necrotic subcutaneous fat was removed at a depth of 0.4 cm and healthy bleeding tissue was observed. The treatment was changed to alginate calcium (promotes healing and the formation of granulation tissue) and was to be applied three times per week. There were no weekly assessments and measurements from 12/21/21 through 1/4/22. A Physician's Order, dated 12/8/21, indicated to swab the right heel daily with betadine and leave the area open to the air.		***will be completed:*** 1/28/22	

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A Physician's Order, dated 1/4/22, indicated the betadine had been discontinued and calcium alginate was to be applied to the right heel on Tuesdays, Thursdays, and Saturdays.

b. The Wound Evaluation Flow Sheet, indicated a deep tissue injury was found on the coccyx on 11/17/21. The measurement of the area was 3 cm by 4 cm with 0.6 cm depth and Santyl cream (debriding agent) with a dry dressing was used for the treatment.

The coccyx measurement on 12/21/21 was 5.6 cm by 2.8 cm with 1.3 cm depth and there was moderate serous drainage. The treatment was Dakin's (antiseptic) solution and cover with a dry dressing twice a day for the treatment.

The Wound Physician's Progress Note, dated 12/21/21, indicated the coccyx measured 5.6 cm by 2.8 cm with 1.3 cm depth. There was undermining at 7 o'clock of 2.7 cm, the surface area was 15.68 cm, there was moderate serous drainage with 80% granulated tissue and 20% dermis. There was no change in the progress and Dakin's solution was to be applied twice a day with a dry dressing covering the area.

The coccyx measurement on 1/4/21 was 4.8 cm by 2.8 cm with 1 cm depth and there was moderate serous drainage. The pressure wound had improved and the Dakin's solution with a dry dressing was to be used twice a day for the treatment.

The Wound Physician's Progress Note, dated 1/4/22, indicated the coccyx measured 4.8 cm by 2.8 cm and was 1 cm depth. The surface area was 13.44 cm. There was moderate serous drainage,

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with 80% granulation tissue and 20% dermis. The wound had improved. The treatment of Dakins solution with a dry dressing twice a day was to be continued.

There were no weekly assessments and measurements from 12/21/21 through 1/4/22.

The Physician's Orders, dated 12/21/21 and 1/4/22, indicated Dakin's solution was to be applied twice a day with dry dressing covering the coccyx area.

c. The Wound Evaluation Flow Sheet form, indicated a pressure ulcer was found on the right knee upon return from the hospital on 12/7/21. The area measured 0.7 cm by 0.6 cm with 0.2 cm depth. The area was covered with 100% epithelial tissue (shiny, light pink appearance). The area was to be covered with a dry dressing and changed three times a week.

On 12/21/21 the right knee measured 0.4 cm by 0.4 cm with 0.1 cm depth. The dry dressing three times a week treatment continued.

The Wound Physician's Progress Note, dated 12/21/21, indicated a stage two (partial thickness of the skin) area on the right anterior knee. The measurement was 0.4 cm by 0.4 cm with depth of 0.1 cm. There was no drainage and the surface area was 0.16 cm. The treatment order was a gauze island with a border dry dressing three times a week.

On 1/4/21, the right knee measured 0.4 cm by 0.4 cm with 0.1 cm depth. There was improved progress and the treatment was changed to clobetasol cream (for redness and swelling) twice a day and cover with a border gauze dressing and kerlix gauze.

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The Wound Physician's Progress Note, dated 1/4/22, indicated the right knee measured 0.4 cm by 0.4 cm with depth of 0.1 cm. There was no drainage and the surface area was 0.16 cm. The area had no change in progress. The treatment order was for a gauze island with a border dry dressing three times a week.

There were no weekly assessments and measurements from 12/21/21 through 1/4/22.

A Physician's Order, dated 12/9/21 indicated to cover the right knee area with a gauze pad dressing on Tuesdays, Thursdays, and Saturdays.

During an interview on 1/20/22 at 3:21 p.m., the Director of Nursing (DON) indicated the Wound Nurse had not worked the days of 12/21/21 through 1/4/22 and the Wound Physician had also been off.

The DON provided "Skilled Nursing Notes", dated 12/22/21 through 1/4/22 on 1/10/22 at 4:26 p.m. and indicated the wounds had been assessed in the notes.

The Skilled Nursing Notes, indicated:
On 12/22/21 at 6:21 p.m., the coccyx open area dressing had been changed, the right heel was "painted" with betadine and the dressing to the right knee was intact.
On 12/23/21 at 4:24 p.m., 12/25/21 at 3:16 p.m., 12/27/21 at 3 p.m., and 12/28/21 at 3:13 p.m., the dressing to the open area to the coccyx was changed, the dressing to the right knee was changed, and the right heel was "painted" with betadine.
On 12/29/21 at 3:38 p.m., the dressing to the

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coccyx was changed, the right heel was "painted with betadine, and the dressing to the right knee was intact.
On 12/30/21 at 4:16 p.m., the dressing to the the coccyx was changed, the dressing to the right knee was changed, and the right heel was "painted" with betadine.
On 12/31/21 at 5:08 p.m., the dressing to the coccyx was changed and the right heel was "painted" with betadine.
On 1/2/22 at 3:56 p.m., the dressing to the coccyx was changed, the dressing to the right knee was intact, and the right heel was "painted with betadine.

There were no wound measurements, descriptions, or actual assessments of the wound status documented.

2) During an observation with RN 1 on 1/10/22 at 10:20 a.m. Resident D was lying in bed. There were heel protector boots on the heels. There was a clean dressing on the right heel. RN 1 indicated she had already changed the right heel dressing earlier in the morning.

Resident D's record was reviewed on 1/10/22 at 4:50 p.m. The diagnoses included, but were not limited to,dementia.

A Significant Change MDS assessment, dated 12/22/21, indicated an intact cognitive status, extensive assistance was needed for bed mobility and dependent for transfers, and there was one stage three (full thickness of skin loss with tissue damage or necrosis) pressure ulcer.

A Care Plan, dated 11/17/21, indicated a pressure ulcer was present. The interventions included, the pressure ulcer would be assessed for location,

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	stage, size (length, width, depth), type of tissue, and the condition of the surrounding skin. A Care Plan, dated 12/7/21, indicated a right heel pressure ulcer. The interventions included treatments as ordered and observe for effectiveness, measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress. Report to the Physician as indicated. Document changes in skin status, appearance, color, wound healing, signs and symptoms of infection and report to the Physician as needed. The Wound Evaluation Flow Sheet form, indicated on 12/21/21, the right heel measured 0.5 cm by 0.9 cm with a depth of 0.3 cm, there was light serous drainage, and the pressure ulcer had improved. The treatment was Iodosorb gel (used for treating wet ulcers and wounds) dressing applied daily. A Wound Physician's Progress Report, dated 12/21/21, indicated a stage three pressure wound on the right heel. The wound measured 0.5 cm by 0.9 cm with a depth of 0.3 cm. The surface area was 0.45 cm, with light serous drainage, 100% granulation tissue, and the wound had improved. The treatment order was for Iodosorb gel to be applied daily and cover with a gauze sponge dressing. The Wound Evaluation Flow Sheet form, indicated on 1/4/21, the right heel measured 2.5 cm by 1.8 cm with 0.3 depth, there was moderate serous drainage, and the pressure ulcer deteriorated. The treatment was changed to calcium alginate three times a week. A Wound Physician's Progress Report, dated			

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1/4/22, indicated a stage three pressure wound on the right heel. The wound measured 2.5 cm by 1.8 cm with a depth of 0.3 cm. The surface area was 4.5 cm with moderate serous drainage, and 100% granulation tissue. The wound progress had deteriorated. The treatment was changed to alginate calcium to be applied daily and covered with a gauze sponge dressing.

There were no measurements or assessments of the right heel pressure ulcer from 12/21/21 to 1/4/22.

A Physician's Order, dated 12/1/21, indicated Iodosorb gel 0.9% to right heel wound daily and cover with a dry dressing.

A Physician's Order, dated 1/4/22, indicated the Iodosorb gel had been discontinued, and calcium alginate was ordered daily to the right heel wound and was to be covered with a dry dressing.

The Skilled Nurse Assessment Notes, provided from the DON as assessments of the wound, on 1/10/22 at 4:26 p.m., indicated:
On 12/23/21 at 3:25 a.m., the dressing to the right heel was changed.
On 12/24/21 at 3:34 a.m., the skin was intact.
On 12/26/21 at 1:29 a.m., the dressing to the right heel was changed.
On 12/27/21 at 12:29 a.m. the skin was intact.

There were no wound measurements, descriptions, or actual assessments of the wound status documented.

A facility policy, dated 4/2017 and titled, "Skin and Wound Management System", was received from the DON as current. The policy indicated an ongoing weekly evaluation of the resident's skin

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	would be completed and documented. The wound status would be documented on the "Wound Evaluation Flow Sheet" form. This Federal tag relates to Complaint IN00370308. 3.1-40(a)(2)			