

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2016
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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953
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F 0000 Bldg. 00	<p>Reed, Shelley This visit was for the Investigation of Complaint IN00209791.</p> <p>Complaint IN00209791-Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: September 19 and 20, 2016.</p> <p>Facility number: 000186 Provider number: 155289 AIM number: 100266300</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 19 Medicaid: 63 Other: 16 Total: 98</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on September</p>	F 0000		
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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 0323 SS=E Bldg. 00	<p>22, 2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure fall prevention measures, such as bed alarms and gait belts, were used to prevent falls in 4 of 5 residents reviewed for accidents. (Resident C, Resident D, Resident E and Resident G)</p> <p>Findings include:</p> <p>1. The clinical record of Resident E was reviewed on 9/20/2016 at 10:38 a.m. The record indicated the resident's diagnoses included, but were not limited to, cognitive communication deficit, history of traumatic brain injury, carotid artery stenosis, polyneuropathy and hypothyroidism. Resident E was discharged to a local hospital on 8/4/2016.</p> <p>A Fall Investigation Worksheet, dated 8/3/2016, indicated Resident E fell at 6:30 p.m. Resident E was being transferred from the wheelchair to the</p>			F 0323	<p>Colonial Oaks Healthcare would respectfully request this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiency noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of the Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies . The plan of Correction is prepared and submitted because of requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. Resident E no longer resides in the facility. All other residents have the potential to be affected by the alleged deficient practice. All alarms that are currently in place have been tested and are</p>		10/19/2016

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	<p>toilet, by a CNA, and turned the wrong way, fell back against the wall and slid to the floor.</p> <p>A care plan, dated 7/22/2016, had the following focus: "I need assistance with my ADLS [Activities of Daily Living] related to dementia, impaired cognition, pain and stiffness, trauma." Interventions included, but were not limited to the following: "I need a gait belt during transfers."</p> <p>During an interview on 9/20/2016 at 11:33 a.m., RN #3 indicated Resident E had fallen on 8/3/2016 while being transferred from the wheelchair to the toilet by a CNA. RN #3 could not remember seeing a gait belt when called to assess Resident E after the fall. "We helped him up after the assessment. He didn't show any signs of increased pain." When asked if a gait belt was used to get Resident E off the floor, RN #3 stated "I don't remember."</p> <p>A request to speak with the CNA involved in the incident was made to the Director of Nursing. The facility was unable to contact the CNA prior to the end of the survey.</p> <p>2. The clinical record of Resident C was reviewed on 9/20/2016 at 8:03 a.m. The</p>		<p>functioning properly. All staff to be in-serviced regarding alarm protocols, and mandatory use of gait belts.</p> <p>Gait belts will be placed in all resident rooms and are required to be on all nursing staff providing resident care.</p> <p>Unit managers to perform audits on alarms daily to ensure they are functioning properly x 4 weeks, 5 times a week for 4 weeks, weekly times 4 weeks and monthly thereafter ongoing.</p> <p>Unit managers will perform a weekly audit/inventory of all gait belts ensuring placement in resident rooms weekly x 4 weeks, every 2 weeks for 4 weeks and then monthly thereafter.</p> <p>DON/designee will review the observation audits upon completion.</p> <p>QA committee will discuss any concerns from observation audits monthly x 6 months then quarterly thereafter until such time as the facility has determined 100% compliance with gait belt use.</p>		

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	<p>record indicated the resident's diagnoses included, but were not limited to, history of falls, osteoporosis, osteoarthritis, hypothyroidism and DVT of the right leg.</p> <p>A Fall Investigation Worksheet indicated Resident C fell on 9/17/2016 at 4:35 p.m. The worksheet indicated Resident C had lost balance while trying to go to the toilet during a self transfer.</p> <p>A current care plan, dated 5/3/2016 and last revised on 8/8/2016, indicated the following focus: "I am at risk for falls related to history of falls, impaired balance, unsteady gait, pain use of narcotic analgesics, use of antidepressant, weakness, difficulty walking." The care plan lacked any documentation for the use of an alarm for fall prevention.</p> <p>A Visual Bedside Kardex Report indicated the following: Safety-" A bed alarm will be used to remind me that I should ask for staff assistance with bed mobility and transfers. Batteries in alarm to be changed per order. A chair alarm will be used to remind me that I should ask for staff assistance with transfers. Batteries to be changed in alarm per order. Bed and Chair pad alarms - Check placement and function every shift. I am going to wear proper footwear or non-slip footwear when I am up. 1/1/2016 Dycem</p>			

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	<p>to be placed in wheelchair to prevent slipping...."</p> <p>During an observation on 9/19/2016 at 4:58 p.m., Resident C was observed in a bed resting quietly. A bed alarm was noted in place. Upon inspection it was noted the alarm was not turned on. Unit Manager #1 turned on the bed alarm and indicated staff should have checked the alarm for functioning. Unit Manager #1 could not explain why the alarm was turned off.</p> <p>3. The clinical record of Resident D was reviewed on 9/20/2016 at 10:07 a.m. The record indicated the resident's diagnoses included, but were not limited to, cerebral infarction, hemiplegia, hemiparesis, cognitive communication deficit, hypertension and peripheral vascular disease.</p> <p>A fall risk assessment, dated 7/25/2016, indicated Resident D had a score of 19 indicating Resident D was a high fall risk.</p> <p>A Fall Investigation Worksheet indicated Resident D fell on 8/31/2016 at 2:41 a.m. The worksheet indicated Resident D thought it was morning and was trying to get out of bed.</p>			

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	<p>A Fall Investigation Worksheet indicated Resident D fell on 9/11/2016 at 2:55 a.m. The worksheet indicated Resident D was trying to turn in bed and slid to the floor. Resident D was found on the floor next to the bed.</p> <p>A current care plan, dated 7/26/2016 and last revised on 8/8/2016, indicated the following focus: "I am at risk for falls related to history of falls related to poor coordination." Interventions included, but were not limited to the following: "A bed alarm will be used to remind me to ask for staff assistance with bed mobility and transfers."</p> <p>A Visual Bedside Kardex Report indicated the following: Safety-" A bed alarm will be used to remind me that I should ask for staff assistance with bed mobility and transfers. Bed alarm - Check placement and function every shift."</p> <p>During an observation on 9/19/2016 at 5:06 p.m., Resident D was observed in a low bed with mats on the floor next to the bed. A bed alarm was noted in place. Resident D was observed moving around in the bed but the alarm was not sounding. Upon inspection it was noted the alarm was not turned on.</p>			

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	<p>During an observation with Unit Manager #1 on 9/19/2016 at 5:25 p.m., Resident D's bed alarm was noted to not be turned on. Unit Manager #1 turned on the bed alarm and indicated staff should have checked the alarm for functioning. Unit Manager #1 could not explain why the alarm was turned off.</p> <p>4. During a morning general observation on 9/20/2016 CNA #4 was observed assisting a Resident G from his wheelchair to the toilet. CNA #4 was not using a gait belt. When asked if the resident required a gait belt for transfers CNA #4 indicated "yes" and further stated "I should have used one." CNA #4 then left the resident unattended on the toilet to get a gait belt.</p> <p>During an interview on 9/19/2016 at 5:25 p.m., Unit Manager #1 indicated all alarms were to be checked at least once a shift for positioning and functioning.</p> <p>During an interview on 9/20/2016 at 9:58 a.m., the Director of Nursing indicated she was aware of the concern related to the functioning of the alarms in the facility. "We just covered fall prevention in an inservice. We recently started putting it on the Treatment Record so the nurses would have to document it as well" The DON indicated the fall</p>			

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	<p>prevention inservices included alarms and gait belt use.</p> <p>Review of the Treatment Administration Records and the task documentation for both Resident C and Resident D indicated the alarms were documented as checked every shift for the past 30 days.</p> <p>Review of a current undated facility protocol titled "Alarms Protocol" indicated the following: "...The use of the alarm is to be documented in the care plan and sent to the POC Kardex under the safety category. ... The task will require the staff to complete documentation that the function ad placement of the alarm has been checked once per shift. ..."</p> <p>A policy, dated 3/2012, titled "Resident Handling Policy, was reviewed on 9/19/2016 at 2:48 p.m. The policy indicated the following: "The Resident Handling Policy exists to ensure a safe working environment for resident handlers... Gait belt usage is mandatory for all resident handling with exception of bed mobility & medical contraindications. The gait belt will be readily available for use...."</p>			

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	No additional policies were provided during the exit conference. This Federal tag relates to Complaint IN00209791. 3.1-45(a)(2)				