

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  04/15/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00147740.</p> <p>Complaint IN00147740-Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F323, F514, and F999.</p> <p>Survey dates: April 11, 13, 14, and 15, 2014</p> <p>Facility number: 000186 Provider number: 155289 AIM number: 100266300</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 16 Medicaid: 65 Other: 20 Total: 101</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000		
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility</p>			

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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	<p>must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure TED hose were applied as ordered by the physician for 1 of 1 resident reviewed with orders for TED hose due to problems with edema of the lower extremities in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>During observations on the following dates and times, Resident #D was up in his chair in his room and was not wearing TED (thrombo-embolytic deterrent) hose as ordered by the physician:</p> <p>4/11/14 at 11:55 a.m. 4/13/14 at 6:55 p.m. 4/14/14 at 10:45 a.m.</p> <p>The resident was wearing regular socks on all of the above occasions. The level of edema could not be observed, but the resident's ankles were very large in appearance.</p> <p>The clinical record for Resident #D was reviewed on 4/11/14 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, congestive heart failure, diastolic heart failure, and hypertension.</p> <p>A quarterly Minimum Data Set (MDS)</p>	F000309	In lieu of survey results the facility respectfully requests a paper review of the plan of correction. The facility is unable to correct the alleged deficient practice for resident number C. All other residents have the potential to be affected by the alleged deficient practice. An audit has been conducted to review all residents with TED hose orders to ensure no other resident has been affected by the alleged deficient practice. Nursing staff will be inserviced regarding TED hose application for residents with current orders by the DON/Designee. A nursing rounds checklist will be utilized by the DON/Unit Managers each day to monitor for appropriate TED hose applications for those residents with current orders. Rounds check list to be reviewed at monthly QA committee meetings on going.	05/09/2014

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	<p>assessment, dated 2/2/14, indicated the resident was not cognitively impaired and required extensive assistance of the staff for bathing and dressing. Resident #D was also identified as alert, oriented, and able to provide reliable information on an "interviewable list" provided by the RN Consultant on 4/11/14 at 10:35 a.m.</p> <p>A health care plan problem, dated 10/21/13 and last reviewed on 2/10/14, indicated the resident had a problem with edema of the lower extremities. One of the approaches for this problem was for the resident to wear the TED hose as ordered.</p> <p>"Weekly skin observation" records, dated 4/3/14 and 4/10/14, indicated the resident had edema of both lower extremities. The records did not indicate the level of edema or any calf or ankle measurements.</p> <p>A current recapitulation of physician's orders, dated 4/14/14, indicated the resident had an order for TED hose to be put on in the morning and removed at bedtime. The original date of this order was 10/22/13.</p> <p>Resident #D was interviewed on 4/14/14 at 10:45 a.m. The resident indicated he always wore regular socks and did not know he was supposed to wear any type of compression and/or "special" socks. He indicated he did not remember ever wearing any special stockings while a resident in the facility. He indicated he was aware he had problems with swelling of his feet and ankles and would be willing to wear the stockings if the doctor thought he needed them.</p> <p>The RN Consultant and DoN were interviewed on 4/14/14 at 2:15 p.m.</p>			

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F000323 SS=D	<p>Additional information was requested related to the resident not wearing the TED hose as ordered by the physician.</p> <p>The facility failed to provide any additional information as of exit on 4/15/14.</p> <p>This federal tag relates to Complaint IN00147470.</p> <p>3.1-37(a) 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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure interventions to prevent possible falls were in place as indicated in the resident's plan of care for 1 of 3 residents reviewed for falls in a sample of 6. (Resident #C)</p> <p>Findings include:</p> <p>During an observation on 4/13/14 at 6:30 p.m., Resident #C was up in her wheelchair in her room. The resident's call light over her door was on. The resident had slid down in her chair and her buttocks were at the edge of the chair seat. CNA #1 entered the room at this time to answer the resident's call light. The resident told CNA #1 she wanted to go to the bathroom and then be put to bed. CNA#1 pulled the resident up in her chair and away from the edge and told her she would get help and return to take her to the</p>	F000323	The facility is unable to correct the previous alleged deficient practice for resident #C. Dysom has been placed in the wheelchair of resident #C.All residents have the potential to be affected by the alleged deficient practice.An audit of care plan interventions has been conducted for any resident potentially utilizing dysom in the wheelchair to ensure that no other resident has or is being affected by the alleged deficient practice.Nursing staff to be in-serviced regarding what dysom is, how it is to be used and the porper use of a clip alarm by the DON/Designee. DON/Unit Managers will conduct daily Nursing rounds utilizing a checklist to ensure those residents requiring dysom to their wheelchairs have it in	05/09/2014			

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	<p>bathroom.</p> <p>CNA #1 returned with CNA #2 within a few minutes. The CNAs rolled the resident's wheelchair into the bathroom and assisted her to stand and take hold of the grab bar on the wall beside the toilet. The CNAs helped the resident onto the toilet. The resident's chair alarm did not sound as she stood up from the chair. The alarm in place was not a pressure pad alarm. It was a clip alarm and the clip and string were hanging down inside of the chair. The clip was not attached to the resident's clothing preventing the magnet from being pulled off of the alarm box in order to make the alarm sound. The resident had been sitting on a dark cushion which had a silkish type cover which was smooth in appearance. There was no Dysom (a thin square of grooved rubber-like material that helps prevent sliding) on the cushion to help prevent the resident from sliding forward in the chair. CNA #1 did not appear to know what "Dysom" was and CNA #2 tried to explain it to her.</p> <p>LPN #3 was interviewed on 4/13/14 at 6:45 p.m., and told of the above observation. When informed there was not any Dysom present in Resident #C's wheelchair, she indicated she would try to get some for the resident.</p> <p>The clinical record for Resident #C was reviewed on 4/11/14 at 2:45 p.m. Diagnoses for the resident included, but were not limited to, Parkinson's disease, anxiety state, peripheral neuropathy, and history of falls.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 2/1/14, indicated the resident required extensive assistance of the</p>		<p>place and that clip alarms are being appropriately attached to the resident. Nursing Rounds Checklist will be reviewed at the monthly QA Committee Meetings ongoing.</p>				

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F000514 SS=E	<p>staff for transfers and toileting.</p> <p>A health care plan problem, dated 7/30/13 and last reviewed on 1/20/14, indicated Resident #C was at risk for falling related to a history of falls, unfamiliar environment, abnormal gait, deformity of ankle and foot and lack of coordination. Two of the approaches for this problem were for the resident to have a "chair pad alarm" and "Dysom to wheelchair".</p> <p>Review of the current facility policy, revised 8/2013, titled "Fall Evaluation and Investigation", provided by the DoN on 4/15/14 at 11:55 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <ol style="list-style-type: none"> <li>To detect root cause of falls to extent possible and to identify supportive aides to prevent falls.</li> <li>To identify high-risk residents and implement interventions to reduce falls and the consequences of falls...."</li> </ol> <p>This federal tag relates to Complaint IN00147470.</p> <p>3.1-45(a)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>						

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	<p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure nursing documentation was complete and accurate in regards to skin assessments, burns from heated rice packs, nursing notes, TED hose application, resident falls, fall interventions, and resident elopements for 4 of 6 residents reviewed for complete and accurate clinical records in a sample of 6. (Resident #'s D, C, E, and F)</p> <p>Findings include:</p> <p>1.a. The clinical record for Resident #D was reviewed on 4/11/14 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, congestive heart failure, diastolic heart failure, and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/2/14, indicated the resident was not cognitively impaired and required extensive assistance of the staff for bathing and dressing. Resident #D was also identified as alert, oriented, and able to provide reliable information on an "interviewable list" provided by the RN Consultant on 4/11/14 at 10:35 a.m.</p> <p>Resident #D was interviewed on 4/11/14 at 11:55 a.m. regarding the reddened areas on his bilateral anterior shoulders noted in</p>	F000514	<p>The facility is unable to correct the alleged deficient practice for resident #C and #D. All residents have the potential to be affected by the alleged deficient practice. An audit has been conducted to review all residents with TED hose orders to ensure no other residents have been affected by the alleged deficient practice. Skin assessments for all residents have been reviewed for the last 30 days to ensure that no other resident has been affected by the alleged deficient practice. DON/Nurse consultant to conduct an in-service with the Nursing staff on documentation of skin assessments, TED hose application, falls/fall interventions and resident elopements. Nurse Consultant to review fall documentation and fall investigations one time a week for 12 weeks and then monthly thereafter ongoing.</p>	05/09/2014

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	<p>January 2014. He indicated the reddened areas were burns he received from heated "rice packs" placed on him by his wife. He indicated she carried the rice packs into his room in her hands and did not think they were that hot. He indicated the rice packs were placed on his anterior shoulders/chest area by his wife and then she left the facility. He indicated he did not realize he was being burned by the rice packs until they were removed later. He indicated he did not know how the rice packs were heated. He indicated the staff treated the burns and they had been healed for a long time. He indicated his wife had been very upset when he was burned from the heated packs she had applied and had immediately taken them home.</p> <p>A nursing note entry, dated 1/13/14 at 11:04 a.m., indicated the Nurse Practitioner was made aware of reddened areas to the left and right shoulder. The note indicated a new order was received for silvadene cream (a topical cream frequently ordered to treat burns) to affected area two times a day. The nursing note lacked any information related to the resident having been burned from heated "rice packs" applied by his wife.</p> <p>An "Initial Non-pressure Skin Report", dated 1/13/14, indicated areas identified in the "other" category, were "first observed" on 1/13/14. The area on the right front shoulder was described as being "4.8 [centimeters] by 4.4 red raised area with 2.5 by 3.0 brown scabbed area in center". The area on the front left shoulder was described as being "3.0 by 1.5 red area with 2.0 by 1.2 scab in center. The "comments section" of the form was blank. The form did not identify the areas noted above as being burns. These</p>			

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	<p>were the only actual measurements of the burns noted in the resident's clinical record. Subsequent skin sheets identified the areas as red areas and no measurements were recorded.</p> <p>Subsequent nursing notes, dated 1/14/14, 1/15/14, 1/16/14, 1/17/14, refer to the resident receiving a treatment to reddened areas. None of the notes identified the areas as having been burns received from the heated rice packs.</p> <p>A nursing note entry, dated 1/18/14, at 3:44 a.m., indicated "Remains alert charting for burns to bilateral chest/shoulder due to rice bag. Zero complaints of pain or discomfort this shift...."</p> <p>The January and February treatment sheets for Resident #D indicated the treatment of Silvadene cream to the "reddened areas" had been provided from 1/13/14 thru 2/26/14. The treatment sheets lacked any information related to the locations of the areas or that the reddened areas were burns from the heated rice packs.</p> <p>The DoN was interviewed on 4/14/14 at 2:15 p.m. Additional information was requested related to the lack of complete and accurate clinical record documentation noted above.</p> <p>The facility failed to provide any additional information as of exit on 4/15/14.</p> <p>1.b. During observations on the following dates and times, Resident #D was up in his chair in his room and was not wearing TED (thrombo-embolytic deterrent) hose as ordered by the physician:</p>			

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	<p>4/11/14 at 11:55 a.m. 4/13/14 at 6:55 p.m. 4/14/14 at 10:45 a.m.</p> <p>The resident was wearing regular socks on all of the above occasions. The level of edema could not be observed, but the resident's ankles were very large in appearance.</p> <p>A current recapitulation of physician's orders, dated 4/14/14, indicated the resident had an order for TED hose to be put on in the morning and removed at bedtime. The original date of this order was 10/22/13.</p> <p>Resident #D was interviewed on 4/14/14 at 10:45 a.m. The resident indicated he always wore regular socks and did not know he was supposed to wear any type of compression and/or "special" socks. He indicated he did not remember ever wearing any special socks while a resident in the facility.</p> <p>The April 2014 Treatment Administration Record for Resident #D indicated the TED hose had been applied every day of the month from 4/1 through 4/14/14 and removed every evening from 4/1 through 4/13/14.</p> <p>The RN Consultant and DoN were interviewed on 4/14/14 at 2:15 p.m. Additional information was requested related to the TED hose having been documented as applied when they had not been on as ordered.</p> <p>The facility failed to provide any additional information as of exit on 4/15/14.</p> <p>2. The clinical record for Resident #C was reviewed on 4/11/14 at 2:45 p.m. Diagnoses</p>			

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	<p>for the resident included, but were not limited to, Parkinson's disease, anxiety state, peripheral neuropathy, and history of falls.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 2/1/14, indicated the resident required extensive assistance of the staff for transfers and toileting.</p> <p>A health care plan problem, dated 7/30/13 and last reviewed on 1/20/14, indicated Resident #C was at risk for falling related to a history of falls, unfamiliar environment, abnormal gait, deformity of ankle and foot and lack of coordination. One of the approaches for this problem was for the resident to have a "chair pad alarm".</p> <p>A "Falls Investigation Worksheet", dated 8/31/13, indicated Resident #C had fallen and had been found outside of the facility at 8:30 a.m. that morning and had been "looking for her husband". The resident sustained an abrasion on her left back. The fall investigation did not indicate the position and/or exact location of the resident when found. The investigation did not indicate whether the resident's chair alarm had been sounding at the time of the resident's fall.</p> <p>The only nursing note entry for 8/31/13 was at 12:05 p.m. The entry indicated the resident had fallen at 8:30 a.m. and had been looking for her husband. The note included a resident assessment at the time of the fall and indicated the resident's physician and family had been notified of the fall. The nursing note lacked any information related to the resident being found outside of the facility at the time of the fall, the position of the resident when found, and/or whether the alarm had been sounding at the time of the</p>			

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	<p>fall.</p> <p>The DoN was interviewed on 4/14/13 at 2:30 p.m. She indicated the resident had fallen when attempting to leave the facility on 8/31/13. She indicated the resident got up from her wheelchair and stepped outside of the door. She indicated the resident had been found just outside the door. She indicated she had reported the unusual occurrence to the ISDH. She indicated she had no information to provide related to the nursing note note and fall investigation not including complete information.</p> <p>3. The clinical record for Resident #F was reviewed on 4/11/14 at 11:05 a.m. Diagnoses for the resident included, but was not limited to, history of head injury from pedestrian versus automobile accident, involuntary movements, anxiety state, and intermittent explosive disorder.</p> <p>A health care plan problem, revised on 12/5/13, indicated the resident was at risk for falls due to a history of falls, impaired balance, unsteady gait.... One of the approaches for this problem was for the resident to have a clip alarm to his wheelchair to alert the staff if he attempted to get up unassisted.</p> <p>A nursing "Behavior Note" form, dated 3/7/14 at 1:40 p.m., indicated "Resident went into [room number of another resident] and laid down on the extra bed. This nurse and nurse aide got resident out of the bed and took him to his own room." The entry lacked any information as to whether the resident's chair alarm had been sounding at the time of the fall or how the staff became aware the resident was in the wrong bed.</p>						

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	<p>A nursing note, dated 3/7/14 at 2:44 p.m., indicated "Resident on alert charting for increase in Lexapro [an antidepressant]. Resident did go into another residents room and refuse to leave today, but otherwise in a pretty good mood."</p> <p>A social service behavior note, dated 3/10/14 at 2:59 p.m., indicated "Staff reports [name of resident] was observed in another bed other than his own. Resident was in the room at the time.... Resident went to nurses station to inform nurse...." The social service note lacked any information as to whether the resident's chair alarm was sounding when he transferred himself into the wrong bed in the wrong room.</p> <p>The DoN was interviewed on 4/14/14 at 2:15 p.m. She indicated she had no information to provide related to the lack of information noted above.</p> <p>4. The clinical record for Resident #E was reviewed on 4/11/14 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, osteoporosis, and anxiety state.</p> <p>The clinical record indicated the resident was receiving hospice services.</p> <p>A self reported incident, dated 2/18/14, indicated the resident had fallen from her bed at 12:00 a.m. The report indicated "Rented electric low bed came apart at junction of headboard and frame, allowing frame to drop down on one corner and resident rolled out of bed onto mat...." The report indicated "Resident was placed in another bed for the night. [Name of bed company] notified, bed</p>			

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	<p>replaced immediately."</p> <p>A fall nursing note, dated 2/18/14 at 6:11 a.m., indicated the resident had fallen in her bedroom at 1:00 a.m. The note indicated "A resident was heard yelling for help. The resident's husband [also a resident in the facility] was found in hall yelling "[name of resident] fell". The note indicated the resident was found on the floor mat. The resident's face had made contact with the floor while her body was on the mat. The note documented assessment information. The note lacked any information related to the headboard of the bed separating from the frame allowing the resident to fall. The note lacked any information related to a problem with the bed or the resident being transferred to another bed for the rest of the night. Subsequent nursing notes through 2/26/14 lacked any information related to the resident's bed being replaced by the hospice provider.</p> <p>The DoN was interviewed on 4/14/14 at 2:50 p.m. She indicated the resident had fallen as indicated in the self reportable note, the headboard had separated from the frame allowing the resident to fall, and the bed had been replaced by the hospice provider. She indicated she had no information to provide related to the nursing notes lacking the complete information as noted previously.</p> <p>5. Review of the current facility policy, titled "Documentation Procedures and Guidelines", revised 1/2012, provided by the DoN on 4/15/14 at 11:55 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>1. To reflect the quality of care provided to</p>						

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	<p>each resident.</p> <p>2. To document the resident's progress toward care plan goals, interventions and responses to treatment.</p> <p>3. To serve as the basis for monitoring activities, education programs, risk management, and other management statistics.</p> <p>...General Guidelines:</p> <p>...3. Any change in condition, will require a written evaluation.</p> <p>4. Medication administration, Treatment administration, and CNA documentation will be entered electronically into the Resident's Medical record.</p> <p>...Nursing Documentation:</p> <p>1. Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable.</p> <p>...3. Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner.</p> <p>4. Required entries will be timely and comply with Medical Records Policies and documentation schedules.</p> <p>5. Late entries must be dated on the date it is written, and will include the date and time that the original entry should have been made....</p> <p>...9. The documentation system is designed to address all pertinent (episodic), and</p>			

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F009999	<p>periodic information in the nursing progress notes."</p> <p>This federal tag relates to Complaint #IN00147470.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> <p>STATE RULES:</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(g)(1) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number ((317) 383-6144) of the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on clinical record review and interview,</p>	F009999	The facility is unable to correct the alleged deficient practice for resident #D. All residents have the potential to be affected by the alleged deficient practice. Skin assessments for all resident have been reviewed for the last 30 days to ensure that no other resident has been affected by the alleged deficient practice. Nurse Consultant to review the Unusual Occurrence Reportable Criteria with the DON/Unit Managers. All initial non pressure skin reports will be reviewed daily during the Departmental Morning Meetings by the Unit Managers/DON to ensure there are no skin issues meeting the State Unusual Occurrence Reportable Criteria. QA Committee to review audit any concerns that were identified during the Departmental Morning Meetings ongoing.	05/09/2014	

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	<p>the facility failed to ensure the Indiana State Department of Health was notified when a resident received burns on his chest and shoulder areas following placement of heated "rice packs" for 1 of 1 resident reviewed who was burned by placement of heated rice packs in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #D was reviewed on 4/11/14 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, congestive heart failure, diastolic heart failure, and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/2/14, indicated the resident was not cognitively impaired and required extensive assistance of the staff for bathing and dressing. Resident #D was also identified as alert, oriented, and able to provide reliable information on an "interviewable list" provided by the RN Consultant on 4/11/14 at 10:35 a.m.</p> <p>An "Initial Non-pressure Skin Report", dated 1/13/14, indicated areas identified in the "other" category, were "first observed" on 1/13/14. The area on the right front right shoulder was described as being "4.8 [centimeters] by 4.4 red raised area with 2.5 by 3.0 brown scabbed area in center". The area on the front left shoulder was described as being "3.0 by 1.5 red area with 2.0 by 1.2 scab in center. The "comments section" of the form was blank. The form did not identify the areas noted above as being burns.</p> <p>A nursing note entry, dated 1/13/14 at 11:04 a.m., indicated the Nurse Practitioner was</p>			

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	<p>made aware of reddened areas to the left and right shoulder. The note indicated a new order was received for silvadene cream (a topical cream frequently ordered to treat burns) to affected area two times a day.</p> <p>A nursing note entry, dated 1/13/14 at 11:15 p.m., now identified as an error and stricken out, read as follows "Resident has treatment for burns to bilateral shoulders. Resident states he can not feel any pain."</p> <p>A nursing note entry, dated 1/14/14 at 12:14 a.m., indicated "Resident continues treatment to bilateral shoulders for red area."</p> <p>Subsequent nursing notes, dated 1/15/14, 1/16/14, 1/17/13, referred to the resident receiving a treatment to reddened areas.</p> <p>A nursing note entry, dated 1/18/14, at 3:44 a.m., indicated "Remains alert charting for burns to bilateral chest/shoulder due to rice bag. Zero complaints of pain or discomfort this shift...."</p> <p>A health care plan problem, dated 1/13/14 and last reviewed on 2/10/14, indicated the resident had 2 reddened areas on anterior bilateral shoulders. The cause of the "reddened areas" was not indicated. Approaches for this problem were "Observe for signs of infection and notify M.D. [medical doctor] if needed" and "Treatment per order".</p> <p>Resident #D was interviewed on 4/11/14 at 11:55 a.m. regarding the reddened areas on his bilateral anterior shoulders noted in January 2014. He indicated the reddened areas were burns he received from heated "rice packs" placed on him by his wife. He indicated she carried the rice packs into his</p>			

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	<p>rooms in her hands and did not think they were that hot. He indicated the rice packs were placed on his anterior shoulders/chest area by his wife and then she left the facility. He indicated he did not realize he was being burned by the rice packs until they were removed later. He indicated he did not know how the rice packs were heated. He indicated the staff treated the burns and they had been healed for a long time. He indicated his wife had been very upset when he was burned from the heated packs she had applied and had immediately taken them home.</p> <p>The January and February treatment sheets for Resident #D indicated the treatment of Silvadene cream to the "reddened areas" had been provided from 1/13/14 thru 2/26/14.</p> <p>The DoN was interviewed on 4/14/14 at 2:15 p.m. regarding the burns received by Resident #D from the heated "rice packs" noted on 1/13/14. She indicated she had not reported this incident to the Indiana State Department of Health as an unusual occurrence.</p> <p>This federal tag relates to Complaint #IN00147470.</p> <p>3.1-13(g)(1)</p>				