STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155289	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL OAKS HEALTH CARE CENTER	4725 S COLONIAL OAKS DR MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 21, 22, 23, 24, and 25, 2023. Facility number: 000186 Provider number: 155289 AIM number: 100266300 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 28 Medicaid: 54 Other: 14 Total: 96 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 30, 2023.	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this 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 provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure	F 0744	Resident #6 has had no adverse reactions as a result of this	09/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaime Sevier	RN	09/05/2023

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	nonpharmacological interventions were attempted prior to the administration of an as needed (PRN) psychoactive medication for 1 of 2 residents reviewed for dementia care (Resident 6). Finding includes: During an observation on 8/21/23 at 11:50 a.m., Resident 6 sat in her wheelchair in the hall and yelled help repeatedly. She indicated she wanted someone to get her car keys. During an observation on 8/23/23 at 11:32 a.m., the resident sat in her room in her wheelchair and made repeated nonsensical sounds which were followed by utterances of "oh, oh, oh" repeatedly. During an observation on 8/24/23 at 10:50 a.m., the resident yelled help repeatedly. She indicated she wanted someone to help her with a note to give the people in the house down the street. Resident 6's clinical record was reviewed on 8/24/23 at 9:32 a.m. Her diagnoses included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, recurrent depressive disorders, and anxiety disorder. Her current physician's orders included buspirone (antianxiety) 5 mg two times a day and escitalopram (antidepressant) 2.5 mg daily. Her 6/24/23 quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired and had verbal behavioral symptoms that were directed toward others and occurred one to three days of the seven-day assessment period.		deficient practice. Resident #6's medication was reviewed by the facility Psychiatric Nurse Practitioner the mentioned medication has been discontinued. All other residents residing in the facility that receive psychoactive medication have the potential to be affected by this deficient practice. The facility policy and procedure for Psychoactive Medications/Gradual Dose Reduction/Unnecessary Medications was reviewed and no changes were indicated. Facility staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for Psychoactive Medications/Gradual Dose Reduction/Unnecessary Medications. The DON and/or designee will complete the Behavior/Nonpharmacological Intervention Documentation form (Attachment A) The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Behavior/Nonpharmacological Intervention Documentation form to ascertain continued compliance at	

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	A care plan for anxiety, initiated on 5/28/19 and revised on 4/20/22, indicated the resident had anxiety as evidenced by chronic disease process and depression. The resident would become easily agitated when anxious or become anxious when she did not know what she was to be doing. She preferred to keep busy. Interventions included incorporate the resident's daily routine as much as possible during her stay (initiated 4/29/20), medications as ordered (initiated 5/30/19), and reassurance as needed (initiated 5/30/19). A care plan for behavioral symptoms, initiated on 12/20/17 and revised on 4/18/22, indicated the resident had behavioral symptoms related to cognitive deficit and dementia such as wandering, resistance to care, easily agitated, yelling/screaming, hitting at others, crying/tearful and cursing when she became confused. The resident would sometimes have repetitive questions such as "I don't know what I am supposed to be doing" when staff were letting her know it was time for bed, breakfast, or to get dressed. Interventions included allow the resident plenty of time to process what is being said before beginning the resident's care (initiated and revised 4/7/22), allow the resident to express her feelings (initiated 12/20/17), approach resident from the front and get her attention (initiated 12/20/17), diversional activity such as going to the next activity on the activities calendar (initiated 12/20/17), reassure and comfort resident when needed to calm her down (8/28/19), redirect the resident's behavior by offering her a crossword puzzle, word search, or offer to take her for a walk, or start a conversation with her about her daughter or her past job (initiated 8/28/19), remove her from stimuli when indicated (initiated 8/28/19), and when the resident becomes agitated allow her		least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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	time to calm and reapproach at a later time (initiated 12/20/17). A Physician's Note, dated 6/13/23 at 7:57 a.m., indicated the resident was COVID-19 positive and placed on droplet isolation. The resident was very anxious and yelled out to get into her wheelchair to visit her brothers (who were not there). She appeared more dyspneic (short of breath) due to her anxiety. The resident experienced increased anxiety due to COVID-19 isolation restrictions and did not want to remain in her room. Lorazepam (antianxiety) 0.25 mg every 6 hours PRN for 10 days was prescribed. The resident's Medication Administration record for June 2023 indicated the resident received the PRN 0.25 mg lorazepam on 6/13/23 at 2:00 p.m. and 9:00 p.m., on 6/16/23 at 11:48 a.m., 6/19/23 at 4:13 p.m., and 6/23/23 at 12:07 p.m. A Nurse Note, dated 6/16/23 at 1:40 p.m., indicated the resident had anxiety due to not being able to leave her room. Lorazepam was given. A Nurse Note, dated 6/23/23 at 1:52 p.m., indicated the resident had anxiety and lorazepam was given. The clinical record lacked documentation of interventions provided prior to administration of lorazepam. During an interview, on 8/25/23 at 2:00 p.m., the Social Services Assistant (SSA) indicated the resident did not have any behavior reports for June 2023 for the resident. During an interview, on 8/25/23 at 2:53 p.m., LPN 51 indicated a resident should be assessed for anxiety symptoms and interventions should be			

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	attempted prior to giving a PRN antianxiety medication. If the non-medication interventions were not successful, then the PRN antianxiety medication would be given. The behaviors and interventions should be documented. She usually filled out a behavior sheet when a resident had behaviors and required a PRN psychoactive medication. During an interview, on 8/25/23 at 3:00 p.m., the Director of Nursing (DON) indicated behavior sheets should be completed for residents who had behaviors. Non-pharmacological interventions should be attempted prior to administration of PRN psychoactive medications. She was unable to locate documentation of the interventions provided for the resident prior to administration of the PRN lorazepam in June 2023. A current facility policy, dated 11/10 and revised 4/23, provided by the DON on 8/25/23 at 3:51 p.m., titled "Psychoactive Medications/Gradual Dose Reduction (GDR)/Unnecessary Medications Policy," indicated the following: " ...Prior to the administration of a prn psychoactive medication, the nurse will attempt non-pharmacological interventions document the interventions attempted and outcomes of the interventions ...." 3.1-37(a)			