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	02/14/2023

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

(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 Complaints IN00400799 and IN00401111. Complaint IN00400799 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00401111 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey dates: February 13 and 14, 2023 Facility number: 000186 Provider number: 155289 AIM number: 100266300 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 31 Medicaid: 53 Other: 17 Total: 101 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 17, 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 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracey Carter	RN,DON	02/27/2023

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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	property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed to prevent neglect of 1 of 3 residents reviewed for neglect. (Resident D) Findings include: The clinical record for Resident D was reviewed on 2/14/2023 at 8:33 a.m. Diagnoses included chronic pain syndrome, paraplegia, acute cystitis with hematuria, anemia, hypertension, anxiety disorder, idiopathic peripheral autonomic neuropathy, ileostomy, stage 4 left hip pressure ulcer, stage 4 sacral region pressure ulcer, stage 4 left buttocks pressure ulcer, stage 4 right buttocks pressure ulcer, stage 3 left heel pressure ulcer, and stage 2 right heel pressure ulcer. The resident was assessed as cognitively intact. A facility self-reportable, dated 2/5/2023, indicated on 2/4 and 5/2023 CNA (Certified Nursing Aide) 1 failed to provide incontinent care to Resident D. The facility investigation substantiated the allegation and CNA 1 self-terminated employment from the facility. A written statement by QMA (Qualified Medication Aide) 2 indicated on 2/4/2023,	F 0600	Resident D has had no adverse reactions as a result of this deficient practice. Resident D's Clinical record has been reviewed and no psychosocial concerns noted. All other residents residing in the facility have a potential to be affected by this deficient practice. Facility policy and procedure for Freedom from Abuse, Neglect, Exploitation and misappropriation of property was reviewed with no changes indicated. Facility staff were re-in serviced by the director of nursing regarding the facility policy and procedure for Freedom of Abuse, Neglect, Exploitation and misappropriation of property. The DON and or designee will complete the (Abuse) Staff Treatment of Resident audit form (attachment A). The random audit will occur weekly for four weeks, every other week for four weeks and then monthly thereafter. Monitoring will continue until one hundred precent compliance is achieved for a period for three	02/15/2023

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	between 12:30 p.m. and 1:30 p.m., CNA 1 came to her and asked her to follow him. He led her to the hallway for Resident D. On the way, they encountered LPN 4, and CNA 1 and LPN 4 started having an argument. QMA 2 and LPN 4 went to the resident's room and began doing his dressing changes, and provided incontinence care. CNA 1 told the QMA he had been taught he could not provide incontinence care to a resident with wounds. A written statement by the DON (Director of Nursing) indicated on 2/4/2023 she received a phone call from QMA 2 stating CNA 1 told staff he was taught he was unable to provide cares to a resident with wounds. The DON indicated she had been CNA 1's instructor and this was not taught in the class. QMA 2 then told the CNA he could provide cares to a resident with wounds. On 2/5/2023, around 5:30 p.m. to 6:00 p.m., the DON stated she received another phone call from QMA 2 indicating CNA 1 was still not providing incontinence care to Resident D. Staff were instructed to send CNA 1 home. A written statement by the DON indicated she had spoken with LPN 4 on 2/6/2023 about the incidents alleged on 2/4 and 2/5/2023. LPN 4 told the DON that between 9:00 a.m. and 10:00 a.m. on 2/4/2023, CNA 1 told her Resident D needed to be changed. LPN 4 told the CNA to go ahead and change the resident and she would do treatments when she completed her medication pass. Sometime after lunch, CNA 1 asked LPN 4 when she was going to do the resident's treatment, because the resident had not been changed all day. LPN 4 told the CNA he was supposed to have provided his care already. Sometime between 1:30 p.m. and 2:00 p.m., the nurse provided care and treatments for the resident.		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 (Abuse) Staff treatment of resident's audit form to ascertain continued compliance at 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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	The resident had been incontinent of stool. A written statement by LPN 4 indicated, at approximately 4:30 p.m., she and LPN 5 were doing wound care for Resident D. The resident stated he had not been changed since 4:30 a.m. The resident was soiled up to the middle of his back with stool. The resident told them CNA 1 had come in several times throughout the day, and said they would come and change him, but they never did. A written statement by LPN 5 indicated on 2/5/2023, at approximately 4:30 p.m., he and LPN 4 went to provide wound care to Resident D's multiple pressure areas on his coccyx and hips. The resident told them he had not been changed since around 5:00 a.m. The resident told them he put his call light on and asked to be changed, and was told by CNA 1 they would be back to change him. LPN 5 indicated when they started the wound care, the resident had stool "all over his bed, up his back and caked in his wounds." During an interview, on 2/14/2023 at 8:00 a.m., Resident D indicated he did not want to talk about the incident involving CNA 1. During an interview, on 2/14/2023 at 1:02 p.m., the DON indicated she had taught CNA 1 in class for the CNA certification about a year ago. The CNA told her he was taught in clinicals he could not care for a resident with wounds. She told him that was not taught and that he could provide care to a resident with wounds, he just could not remove the dressings. "I had not worked with him in about a year. I have no idea where he got that. I do not know why he did not do what he should have done."			

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	During an interview, on 2/14/2023 at 1:17 p.m., CNA 8 indicated she was working the weekend of 2/4/2023. She was asked to assist with a dressing change for the resident by LPN 5. The CNA indicated she rolled the resident to his side, he had stool everywhere, and his dressings had come off. She indicated the stool appeared fresh. During an interview, on 2/14/2023 at 1:34 p.m., LPN 4 indicated she was the nurse for both halls. CNA 1 asked if she had looked at Resident D's wounds. She told him she would when she finished the medication pass. The CNA indicated the resident needed to be provided care. She told him to go ahead and change him, the dressings were foam, and if the water proof one came off to let her know. This was about around 9:00 a.m. At 1:00 p.m., she started doing the treatments. He had BM up his back, and some of it was dry. The resident said he had not been touched all day. Then, the next day, the same thing happened. The CNA did not touch resident all day. They called the administrator and he was sent home. Review of a current policy, dated 10/17/2022, titled "Freedom from Abuse, Neglect, Exploitation and Misappropriation of Property" indicated the following: ".... Definitions: ....Neglect - the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...." No other information was provided prior to exit. This Federal tag relates to complaint IN00401111. 3.1-27(a)(3)			