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	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 the Investigation of Complaint IN00375792. Complaint IN00375792 - Substantiated. Federal/state deficiency related to the allegation is cited at F689. Survey date: March 31, 2022 Facility number: 000186 Provider number: 155289 AIM number: 100266300 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 32 Medicaid: 54 Other: 16 Total: 102 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1 Quality review completed on April 4, 2022.	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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident received only medication ordered (Resident B) and failed to ensure a resident received a medication as ordered by physician (Resident C) for 2 of 4 residents reviewed for medication administration. Findings include: 1. The clinical record for Resident B was reviewed on 3/31/22 at 8:49 a.m. Diagnoses included, but were not limited to, fracture of right femur, Parkinson's disease, protein malnutrition, and artificial right hip joint. The most recent admission Minimum Data Set (MDS) assessment, dated 12/24/21, indicated the resident admitted on 12/21/21 from the hospital. The resident was severely cognitively impaired. A progress note, dated 12/29/21 at 2:53 p.m., indicated the system identified a black box warning for levothyroxine (used to treat hypothyroidism). A progress note, dated 12/29/21 at 3:30 p.m., indicated the resident was seen for an acute visit by the Nurse Practitioner (NP). The NP was aware of the current medication regimen containing potential drug interaction and black box warning. A physician's order, dated 12/30/21, indicated to give levothyroxine 175 mcg daily for low thyroid hormone.	F 0689	Resident B and C had no adverse reaction as a result of this deficient practice. Resident B and C's charts were reviewed prior to the survey. The medication error was noted and documented. Appropriate notifications were made, and review of error completed. All residents residing in the facility that have physician's orders for medication administration have the potential to be affected by this deficient practice. The facility policy and procedure for Following Medication-Physician Orders/Parameters and Medication Errors and Drug Reactions were reviewed and no changes were indicated. Nursing staff were re-inserviced by the Director of Nursing regarding the facility policy and procedure for Following Medication-Physician Orders/Parameters and Medication Errors and Drug Reactions. The DON/designee will randomly audit five physician orders a day for completion, accuracy, and implementation; the audit will be documented on the Physician order log (Attachment A). The random audit will occur daily for four weeks, three times a week for four weeks, then monthly thereafter. Any concerns noted will receive	04/01/2022

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	A progress note, dated 1/4/22 at 2:28 p.m., indicated a new order was entered into the system for calcium 600 D twice daily. The order triggered a possible drug interaction with the following medication: a. Aspirin 325 mg b. levothyroxine 175 mcg. A progress note, dated 1/4/22 at 2:39 p.m., indicated the NP reviewed laboratory results and ordered the following: a. Calcium 600/400 mg twice daily. b. Ergocalciferol 5000 units weekly for 12 weeks. c. Vitamin D lab on 3/30/22. d. Ionized calcium lab level on 1/18/22. A progress note, dated 1/5/22 at 11:45 a.m., indicated a new order for oyster shell calcium with vitamin D 500-200 mg tablet identified a black box warning for levothyroxine 175 mcg. The severity was considered moderate and indicated the calcium salts may decrease the pharmacologic effects of levothyroxine. A progress note, dated 1/18/22 at 8:49 a.m., indicated the NP completed a discharge visit for Resident B. The NP was aware of the potential drug interactions and black box warnings. An NP discharge assessment/plan, 1/18/22 at 11:40 a.m., indicated the resident had hypothyroidism and was stable on oral levothyroxine. The resident was discharged to home with 24 hour care following surgical repair of a hip fracture. A Medication Review Report, signed by the NP on 1/18/22, indicated to take levothyroxine 175		immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Physician Order Log review form to ascertain continued compliance at least biannually. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	mcg daily for low thyroid hormone. A new order, dated 1/19/22 at 2:37 p.m., indicated the NP was aware the ionized calcium was canceled. A ionized calcium lab test was completed on 1/20/22 and found to be within normal limits. Review of the Medication Administration Record (MAR), the medication was given daily from 12/30/21 through 1/20/22. A progress note, dated 1/21/22 at 4:34 p.m., indicated the resident's caregiver arrived to transport the resident home. A progress note, dated 1/21/22 at 4:45 p.m., indicated while reviewing the chart, it was noted Resident B had an order for levothyroxine 175 mcg. The medication was ordered on 12/29/21 and was a medication transcription error. The physician and Power of Attorney (POA) were notified. 2. The clinical record for Resident C was reviewed on 3/31/22 at 11:44 a.m. Diagnoses included, but were not limited to, hypothyroidism, chronic obstructive pulmonary disease, anxiety disorder, acute and respiratory failure. The most recent quarterly MDS assessment, dated 12/23/21, indicated the resident cognitively intact. A health care plan, dated 12/30/21, indicated the resident had below normal thyroid function. Interventions included, but were not limited to,			

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	receive thyroid hormone replacement as ordered. A progress note, dated 1/25/22 at 9:28 a.m., indicated during chart review it was noted the resident was to have an increase in levothyroxine 175 mcg on 12/29/21. A transcription error was noted in the chart and a follow-up Thyroid Stimulating Hormone (TSH) level was ordered. An NP discharge assessment/plan, 12/29/21 at 10:19 a.m., indicated the resident had hypothyroidism and a recent TSH level was 7.4 milliunits per liter (mU/L). A repeat TSH was schedule for 12/29/21. A laboratory test result, indicated the TSH level on 12/29/21 was 6.280. The normal TSH level was between 0.465 and 4.680 mU/L. A progress note, dated 12/29/21 at 2:50 p.m., indicated the NP was made aware of the current TSH level and it had improved sine the prior level. A new order was received to increase "Synthroid [levothyroxine] to 175 mcg QD [daily]." A Medication Review Report, signed by the NP on 12/29/21, indicated to take levothyroxine 150 mcg daily for low thyroid hormone. During an interview on 3/31/22 at 9:59 a.m., the Director of Nursing (DON) indicated the person who normally put in orders was on vacation so LPN 1 was doing her job, as well as, the charge nurses job. LPN 1 accidentally put in the order for the wrong person. Orders were read daily in their morning meeting and nothing triggered that is was an error. On 3/31/22 at 10:22 a.m., LPN 1 indicated the			

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	charge nurse was on vacation and she possibly had two screens up and put it on the wrong chart. Neither resident had any adverse drug reaction from the medication. When a resident was admitted, the charge nurse entered the orders and then the unit managers would read through the nurses' notes and orders. The error was caught when the nurse went over discharge instructions with Resident B's caregiver. When he got home, he call back and had questions about the medication and realized it was an error at that time. A current facility policy, dated October 2010, titled "MEDICATION ERRORS AND DRUG REACTIONS," provided by the DON on 3/31/22 at 1:56 p.m., indicated the following: "Policy: 1. To safeguard the resident. 2. To identify causes and prevent future errors.... General Guidelines: 1. All medication, treatment errors, and drug reactions must be reported promptly. Notify the attending physician or Medical Director...." This Federal tag relates to complaint IN00375792. 3.1-37(a)			