STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 01 B. WING	09/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/03/13 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Colonial Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility is a two story fully sprinklered building determined to be Type V (111) construction with a lower level located in the basement with additions and updates made prior to March 1, 2003. The facility has a fire alarm system with hard wired smoke	K010000		

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

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	detection in the corridors, in spaces open to the corridors, and in C hall first floor resident rooms. All other resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 55 and had a census of 39 at the time of this survey. All areas where the residents have customary access and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/06/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K010021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure a door in 2 of 2 basement smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents accessing the physical therapy room. Findings include: Based on observation with the maintenance director on 09/03/13 at 1:25 p.m., one door in each of the two smoke barrier double door sets in the basement failed to close when tested twice to ensure its proper operation. The door coordinators on each door frame held the door with the astragal open, the second	K010021	K-021 Smoke doors (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The two smoke door coordinators in the basement have been repaired to release and close properly. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, staff member, visitor or vender had the potential to be affected, but none were identified. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been re-educated as to the required components of this tag. A smoke door safety audit has been added to the life safety rounds to check for proper	10/03/2013

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	door closed and the coordinator failed to release the first door leaving an six inch gap. The maintenance director acknowledged at the time of observation, the coordinator was malfunctioning. 3.1-19(b)		closing and gap. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The NHA/maintenance director will make weekly walking rounds to check the proper operation of the coordinators on the smoke doors for the next four weeks and monthly thereafter. A quarterly monitoring by the director of plant operations/designee will be conducted. A report of their findings will be discussed at the monthly risk management/QA meeting to determine when compliance has been met. (e) Date of compliance: 10-03-13	

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure wall smoke barrier penetrations in 1 of 3 lower level smoke compartments were sealed in a manner which maintained the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and 10 or more residents in the dining room adjacent to the elevator equipment room. Findings include:	K010025	K-025 Smoke barriers (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: a). The Three inch pipe and two by four inch metal chase penetration in the elevator-equipment room has been cleaned of all expandable foam and all penetrations have been sealed with a fire rated material. b). The six conduit penetrations around the ceiling and walls in the elevator equipment room have been filled with fire rated caulk. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A complete audit was conducted to look for any other penetrations in the elevator equipment room. None were found. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance	10/03/2013

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	a. Based on observation with the maintenance director on 09/03/13 at 1:25 p.m., a three inch pipe and a two by four inch metal chase penetration in the elevator equipment room all were sealed with expandable foam. The maintenance director said at the time of observation, outside contractors had sealed the penetrations, and said he thought the foam was good for preventing the passage of smoke. b. a. Based on observation with the maintenance director on 09/03/13 at 1:25 p.m., six conduit penetrations in the elevator equipment room ceiling and wall were unsealed leaving one half to one inch gaps around the penetrations. The maintenance director acknowledged at the time of observation, the gaps should have been sealed. 3.1-19(b)		director has been re-educated as to the required components of this tag to look for and fill all penetrations with a fire rated material or caulk. Any areas found will be addressed immediately. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they make their weekly walking rounds to check areas for non-fire rated foam for the next four weeks and bi-monthly for two months. This will be an ongoing plan of correction. A quarterly monitoring by the director of plant operations/designee will be conducted. A report of their findings will be discussed at the monthly risk management/QA meeting to determine when compliance has been met. (e) Date of compliance: 10-03-13	

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure egress for 2 of 6 first and second floors exits was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff and 28 residents on the second floor and first floor "C" wing. Findings include: a. Based on observation with the maintenance director on 09/03/13 between 12:35 p.m. and 3:15 p.m., egress at the bottom of of the covered west exit egress stairway from the second floor was blocked by rakes and other "lawn equipment" lying haphazardly across the foot of the stairs. A charcoal grill was located just outside the exit discharge. The maintenance director said at the time of observations, the implements had been stored in the stairway by contractors and	K010038	K-038 Egress exits and doorways readily accessible at all times (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: a). The egress at the bottom of the covered West exit has been cleared of the rakes and other “lawn equipment” to include the removal of the grill.b). The egress for C wing has been corrected at time of survey. The eight foot table was removed at that time.c). The egress through the C wing smoke barrier door has been opened and unblocked and the over bed tables and trash receptacle have been relocated. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, staff member, visitor or vender has the potential to be affected, but none were identified. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been educated to the importance of this tag. That all egresses shall be free of obstructions or obstacles at “all times” and any issues will be corrected immediately. (d) How the corrective action(s) will be	10/03/2013

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	the grill was put there by staff. b. Based on observation with the maintenance director on 09/03/13 between 12:35 p.m. and 3:15 p.m., egress for the C wing was blocked by an eight foot table located across the middle of the C wing exit corridor. Two wheelchair bound ladies sat at the table. A three foot path of egress remained. The maintenance director said at the time of observation, the table had been used for additional dining space. The table was removed at the request of the surveyor at the time of observation. c. Based on observation with the maintenance director on 09/03/13 between 12:35 p.m. and 3:15 p.m., egress through the C wing smoke barrier exit double door set was blocked by the east door which was kept closed with overbed tables parked on both sides of the closed door. The arrangement left available egress through the west door which had the width diminished by a trash receptacle which reduced the available egress width an additional six inches. The maintenance director acknowledged at the time of observations, the clear width of the exit corridor was not being maintained. 3.1-(19)		monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The NHA and maintenance director will make daily walking rounds to insure all egresses are free of any obstructions at all times. This will be an ongoing plan of correction. A quarterly review will be conducted by the director of plant operations/designee. A report of their finding will be discussed at the monthly risk management/QA meeting to determine if compliance is being met. (e) Date of compliance: 10-03-13	

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K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the kitchen were free of foreign materials, such as grime and corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects could affect visitors, staff, and 10 or more residents in the adjacent dining room. Findings include: Based on observation during a tour with the maintenance director on 09/03/13 at 2:50 p.m., two sprinkler heads in the kitchen were covered with a gray fuzzy grime. Both were turning green, usually evidence of corrosion. The maintenance director acknowledged at the time of observation, the sprinkler heads should be in better condition. 3.1-19(b)	K010062	K-062 sprinkler system maintenance. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The two sprinklers in the kitchen have been replaced with new sprinkler heads. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Residents, staff, visitors and venders have the potential to be affected, however none were identified. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been re-educated to the required components of this tag and will do a complete audit on all sprinkler heads and any issues will be addressed immediately . (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The NHA and/or the maintenance director will check the sprinkler heads weekly for four weeks and monthly thereafter. A quarterly inspection	10/03/2013

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			by the Director of plant operations/Designee will be conducted. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met. (e) Date of compliance: 10-03-13	

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K010147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords and multitap adapters were not used as a substitute for fixed wiring on 3 of 3 floors. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect occupants on all three levels. Findings include: Based on observation with the maintenance director on 09/03/13 between 12:45 p.m. and 3:00 p.m., extension cords or multitap outlet adapters were used to provide power to equipment in: a. the second floor TV lounge, an adapter; b. Room 114, an extension cord to power a nebulizer and oxygen concentrator; c. Room 112, a power strip on the resident bed side wall; d. Rooms 106 and 122, extension cords; e. Physical therapy, a power strip for the refrigerator;	K010147	K-147 Electrical wiring/Standard (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: a). The multi plug adapter has been removed from the second floor T.V. lounge.b). The extension cord has been removed from room 114.c). The power strip has been removed from room 112.d). The extension cords have been removed from rooms 106 and 122.e). The refrigerator in therapy has been plugged directly to the wall outlet and the power strip has been removed..f). The power strip and extension cord have been removed from room 108.g). The multi plug adapter has been removed from the T.V. in the main lounge. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facilty audit was completed to locate any other extinction cords or multi plug adapters. None were found. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been re-educated as to the required components of this tag.	10/03/2013

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	f. Room 108 a power strip under the resident bed and an extension cord plugged into the bed side wall to power an air conditioner; g. Behind the TV in the main lounge, an adapter; The maintenance director acknowledged at the time of observations, this electrical equipment was in use. 3.1-19(b)		The standard monitoring and any needed adjustments identified will be done during routine life safety, preventive maintenance rounds as the maintenance director checks for extinction cords and multi plud adapters. Any issues will be corrected immediately. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they do their daily walking rounds. This will be an on-going standard. A quarterly review will be conducted by the director of plant operations/designee and a report of their findings will be reviewed at the monthly Risk Management/QA meeting to assure that compliance is being met. (e) Date of compliance: 10-03-13	