

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/03/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/08/13</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this PSR 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.</p> <p>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</p>	K010000	We are requesting paper compliance for this survey. The plan of correction is to serve as Colonial Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Colonial Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of admission of the survey allegation.	

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>March 1, 2003. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors, and 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.</p> <p>All areas where the residents have customary access with the exception cited at K56. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K010021 SS=E	<p>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:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 self closing doors providing access to the laundry, an area greater than 100 square feet designated as a hazardous area, were held open only by devices allowing the doors to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents in the adjacent activity area.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/08/13 at 12:40 p.m., two doors providing access to the unoccupied laundry were prevented from closing by wooden wedges. The maintenance director acknowledged at the time of observation, the room which held</p>	K010021	<p>1. The wedges we taken away from the Laundry Department. 2. In-services were conducted with the staff, explaining to the staff the need for self closing doors not to be propped open.3. All Department Managers are monitoring on a daily basis to ensure that all self closing doors remain closed.</p>	11/22/2013
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	<p>the collected soiled linen receptacles for the facility should not have been wedged open.</p> <p>This deficiency was cited on 09/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

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K010025 SS=E	<p>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</p> <p>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 in the lower level smoke compartment.</p>	K010025	<p>1.The maintenance man sealed the wall smoke barriers in the kitchen and elevator room.2. The maintenance man inspected all the other areas to ensure no other areas had penetrations.3. The maintenance man will be responsible for inspecting the barriers on a weekly basis.4. Facility is confidence that a weekly inspection and review at QAA is sufficient to ensure no further issues.</p>	11/22/2013

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	<p>Findings include:</p> <p>a. Based on observation with the maintenance director on 11/08/13 at 12:30 p.m., a three inch pipe penetration in the elevator equipment room wall was sealed with expandable foam. The maintenance director said at the time of observation, he had not yet finished removing and resealing the penetration gaps which had been sealed with foam.</p> <p>b. Based on observation with the maintenance director on 11/08/13 at 12:30 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.</p> <p>This deficiency was cited on 09/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure openings through a ceiling smoke barrier in 1 of 3 lower level smoke compartments was maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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. This deficient could affects visitors, staff and 10 or more residents on the lower level.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/08/13 at 1:00</p>	K010029	<p>1.The maintenance man sealed the wall smoke barriers in the kitchen and elevator room.2. The maintenance man inspected all the other areas to ensure no other areas had penetrations.3. The maintenance man will be responsible for inspecting the barriers on a weekly basis.4. Facility is confidence that a weekly inspection and review at QAA is sufficient to ensure no further issues.</p>	11/22/2013	

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	<p>p.m., a one inch hole in the kitchen ceiling was unsealed. The maintenance director said at the time of observation, contractors had drilled the hole while moving sprinkler heads. The work was completed. He acknowledged the gaps should have been sealed.</p> <p>3.1-19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide combustible canopy sprinkler coverage for the exit discharge for 1 of 4 first floor emergency exits. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice affects visitors, staff and 8 or more residents on A hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/08/13 at 12:30 p.m., sprinkler protection was not provided for the ten by thirty foot covered porch on the front of the building which serves as an exit discharge for A hall residents on the first floor. The</p>	K010056	<p>1. on 11-14-13, Safe Care installed the sprinklers for the canopy.2. Safecare will continue coming on a quarterly basis for sprinkler inspections to ensure they are in working order.3. Leadership team will review at QAA safety committee.</p>	11/22/2013

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	<p>maintenance director acknowledged at the time of observation, the porch ceiling, constructed with painted plywood supported by a wood frame, was not protected by sprinklers. Four holes were evident where sprinklers were to be installed but the maintenance director said the contractor had not done it yet.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K010147 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring on 2 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 visitors, staff, and 10 or more residents on the first floor and lower level.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 11/08/13 between 12:05 p.m. and 1:30 p.m., a power strip extension cord was located under the resident bed in room 108 to supply power to the medical grade mattress, oxygen concentrator and other equipment. The maintenance director acknowledged at the time of observations, this electrical equipment was in use.</p> <p>b. Based on observation with the maintenance director on 11/08/13 at 12:15 p.m., four strings of icicle lights were strung along the 26 foot length of</p>	K010147	<p>1. All flexible cords have been removed from use in the facility.2. All staff has been in-service on not using flexible cords and multi-cord adaptors for fixed wiring.3. The maintenance man will monitor on a daily basis that is will be adhered to.4. Th Maintenance man will bring to safety committee.</p>	11/22/2013

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	<p>the lay in ceiling of the open area in the lower level used for resident activities. The lights were connected to five different extension cords which laid above the lay in ceiling and snaked out to reach electrical outlets located on the walls near the ceiling at intervals around the space. The maintenance director said at the time of observation, the installation was temporary.</p> <p>This deficiency was cited on 09/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			