

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 09/29/2014
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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 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).</p> <p>Survey Date: 09/29/14</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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.</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 March 1, 2003. The facility has a fire</p>	K010000		

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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K010017 SS=E	<p>alarm system with hard wired smoke detection in the corridors, 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 44 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/02/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift</p>			

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	<p>shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure use areas were separated from the corridors by a partition capable of resisting the passage of smoke on 1 of 3 floors as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect residents, staff and 10 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 09/29/14 at 11:30 a.m., the corridor access door from the MDS office had a two by twelve inch opening cut out 36 inches from the floor. A metal frame around the opening appeared to be part of a mail slot for which there was no cover</p>	K010017	<p>1. Upon surveyor observation and notification of this requirement the mail slot was reinstalled. 2. A full round of the building was conducted to ensure no like circumstances were present. 3. Smoke partitions in place and uncompromised will be added to the facility monthly round sheet audit tool. This audit will be completed monthly by the Facility Maintenance Director. 4. The results of this audit will be reported to the Quality Assurance Committee on a monthly basis for no less than 6 months. 5. October 29, 2014</p>	10/29/2014

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K010025 SS=E	<p>and the office was therefore open to the corridor. The office was not protected by an electrically supervised automatic detection system. The maintenance director said at the time of observation, he was unaware the opening to the corridor required additional protection.</p> <p>3.1-19(b)</p> <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 ceiling 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</p>	K010025	<p>1. Upon surveyor observation of the three conduit penetrations in the elevator equipment room ceiling, the penetrations were sealed in a manner which maintain the required fire resistance. 2. A complete round of the building was conducted to ensure no like circumstances were present. 3. Absence of smoke barrier penetrations will be added to the Facility Monthly Safety Round Audit Tool. This</p>	10/29/2014			

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K010046 SS=E	<p>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.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/29/14 at 12:15 p.m., three conduit penetrations in the elevator equipment room ceiling were incompletely sealed leaving leaving one fourth to one half inch gaps around the penetrations. The maintenance director acknowledged at the time of observation, the gaps were not completely sealed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 west</p>	K010046	<p>audit will be completed on a monthly basis by the Facility Maintenance Director on a Monthly basis. 4. The results of this audit will be reported to the Quality Assurance Committee on a monthly basis for no less than 6 months. 5. October29, 2014.</p> <p>1. Upon surveyor observation of the battery powered emergency lighting on the second floor west</p>	10/29/2014			

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	<p>exit stairway battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 10 residents on the second floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 09/29/14 at 1:20 p.m., the battery powered emergency exit light fixture provided to illuminate the enclosed west exit stairway from the second floor failed to illuminate when tested twice. The maintenance director said at the time of observation, he did not know the light was not working.</p> <p>3.1-19 (b)</p> <p>2. Based on record review and interview, the facility failed to provide complete documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours of 9 of 9 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for</p>		<p>stairwell failing to illuminate, the device was replaced and tested to ensure it was in working order.</p> <p>As it relates to periodic functional testing of the battery powered emergency lighting fixtures, the facility is unable to retrospectively address the cited concern. 2. All battery powered emergency lighting fixtures in the building were tested to ensure they are all in working order. 3. A form has been developed that lists the location of each of the battery powered emergency lighting fixtures in the building. Building Maintenance will be required to document the required 30 second monthly functional test and annual one and a half hour test on the form. 4. The results of the monthly/ annual testing will be reviewed by the Quality Assurance Committee on a monthly basis for no less than 6 months. 5. October 29, 2014</p>	

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	<p>not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on review of the Emergency Back Up Light Test records with the maintenance director and administrator on 09/29/14 at 2:20 p.m., the battery powered emergency light test records noted 30 Second Monthly Test followed by a list of the months of the year with a date for each of the appropriate months to date. Another note, 90 Minute Annual Test, noted 01/05/14 as the date for the 1 1/2 hour annual test of all battery powered emergency lighting fixtures. The maintenance director said at the time of observation, he used the records provided and these entries reflected the testing for all battery back up emergency lighting fixtures. He said there was nothing documenting how many fixtures there were, their location and test result for each fixture.</p> <p>3.1-19(b)</p>				

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the</p>	K010050	<p>1. As it relates to missing fire drill records the facility is unable to retrospectively address the cited concern. 2. After a complete review of all current fire drill records, the facility is confident there are no like circumstances. 3. A fire drill schedule has been put into place to ensure all fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 4. The aforementioned fire drill records will be reviewed monthly</p>	10/29/2014

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	<p>maintenance director and administrator on 09/29/14 at 2:40 p.m., there was no record of a third shift fire drill for the third quarter of 2013 and the first quarter of 2014. A second shift drill was missing for the fourth quarter of 2013. The maintenance director said at the time of record review he provided all available documentation of fire drills conducted in the past year.</p> <p>3.1-9(b) 3.1-51(c)</p>		<p>by the Quality Assurance Committee for no less than 6 months. 5. October 29, 2014</p>				
K010069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation, the facility failed to install and maintain cooking facilities in accordance with the requirements of NFPA 96, 3-1 which requires listed grease filters, baffles, or other approved grease removal devices for use with commercial cooking equipment shall be provided. Listed grease filters shall be</p>	K010069	<p>1. Upon surveyor observation and notification that mesh grease filters are not to be used; the mesh filters were replaced in accordance with NFPA 96, 3-1. 2. The facility is equipped with a single range hood. Therefore, we are confident there are no like circumstances. 3. The facility is confident that replacement of the mesh filters on the commercial range hood will ensure that this</p>	10/29/2014			

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K010144 SS=F	<p>tested in accordance with UL 1046, Grease Filters for Exhaust Ducts. Mesh filters shall not be used. This deficient practice could affect visitors, staff, and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation of the commercial kitchen range hood with the maintenance director on 09/29/14 at 2:55 p.m., mesh filters were in place to collect grease from cooking vapors. The maintenance director said at the time of observation, he did not know mesh filters were not permitted. A review of commercial kitchen range hood Fire Systems Report dated 08/18/14 with the maintenance director and administrator on 09/29/14 at 2:50 p.m., noted "mesh filters" were in place.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on interview and record review, the facility failed to provide the complete documentation for testing 1 of 1</p>	K010144	<p>practice will not recur. 4. The facility Maintenance Director and Dietary Manger have been educated on the requirements for commercial range hoods. The facility Range hood will be observed on a monthly basis to ensure it is cleaned and maintained as required. If a concern is identified it will be reported to the Quality Assurance Committee at that time.</p> <p>5. October 29, 2014</p> <p>1. As it relates to the complete documentation for testing the emergency generator the facility</p>	10/29/2014			

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	<p>emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires that monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires that generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Test Log maintenance and testing records for the emergency generator with the maintenance director and administrator on 9/29/14 at 3:15 p.m., the emergency generator was tested weekly under load for two and a half hours. Another entry noted the generator was tested "under full" load monthly.</p>		<p>is unable to retrospectively address the cited concern. As it relates to the required letter of reliability from the natural gas vendor;the facility contacted our natural gas provider and obtained a reliability letter that contains the required details. 2. The facility is equipped with a single natural gas powered generator. Therefore, the facility is confident that there are no like circumstances. 3. As it relates to generator testing and required documentation; Administration and Building Maintenance have been educated on the generator testing requirements specific to the current equipment. A form has been put in place that will include all the required generator set testing in accordance with NFPA 110 and NFPA 99. The aforementioned natural gas generator reliability letter will be retained with all generator related materials for future reference. 4. The results of all generator testing will be submitted to the Quality Assurance Committee for review on a monthly basis for no less than 6 months. The reliability letter will be reviewed by the Quality Assurance Committee and the Safety Committee in the month of November. 5. October 29, 2014.</p>	

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	<p>There was no entry to reflect the generator transfer time. The maintenance director said at the time of record review, the generator ran under load automatically every week and the monthly load reference was just copied from a previous document. He said monthly load test measurements, such as the voltage and percentage of the generator under load during testing, were also rewritten from previous records because he had not been trained for the required documentation. He also said he did not actually know what load was carried each time the generator ran although he'd noted "30 %."</p> <p>Additionally, the maintenance director said, he was not trained to transfer the load to the generator should the automatic transfer switch fail. The administrator agreed at the time of record review, the generator contractor should work with the maintenance director to familiarize him with the components and operation of the emergency generator.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to provide evidence to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby</p>			

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	<p>Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ul style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural 			

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K010147 SS=E	<p>gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation of the emergency generator with the maintenance director at 2:45 p.m. on 9/29/14, the fuel source for the emergency generator was natural gas. The maintenance director confirmed, at the time of observation, there was no liquid fuel back up for the generator. Based on interview with the administrator at 3:00 p.m. on 9/29/14, the facility did not have documentation from their natural gas provider confirming the reliability of the fuel source for the generator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>				

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 09/29/2014
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	<p>1. Based on observation and interview, the facility failed to ensure a wet location for 1 of 3 basement level smoke compartments was provided with ground-fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent basement level dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 09/29/14 at 11:30 a.m., the electrical outlet in the basement level bathroom near the administrator's office was located 24 inches from the sink. The outlet was not provided with GFCI protection to prevent electric shock. The</p>	K010147	<p>1. Upon surveyor observation and notification of the requirement for the electrical outlet in the basement level bathroom to be equipped with a GFCI protection the outlet was replaced to meet this requirement. Upon surveyor observation of the use of power strips and extension cords to provide power to a refrigerator and microwave in the Social Service office, the power strip and extension cord was removed and these items were plugged into fixed wiring. 2. As relates to GFCI outlets; a complete round of the building was conducted to ensure no like circumstances were present. As it relates to the presence of power strips/ extension cords in place of fixed wiring; a complete round of the building was conducted to ensure no like circumstances were present. 3. GFCI outlets present in wet locations will be added to the facility Monthly Safety Observation Round audit tool. This audit will be completed monthly by the facility Maintenance Director. Absence of power strips/ extension cords will be added to the facility Monthly Safety Observation Round audit tool. This audit will be completed monthly by the facility Maintenance Director. 4. The results of this audit will be reviewed by the Quality Assurance Committee on a monthly basis for no less than 6 months. 5. October 29, 2014.</p>	10/29/2014

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	<p>maintenance director said at the time of observation, he did not know the outlet should have had GFCI protection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring on 1 of 3 floors. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 basement level where the dining room and activities room were located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 09/29/14 between 11:30 a.m. and 2:00 p.m., power strip extension cords were used to provide power to a refrigerator and microwave in the social services office and a coffee pot and toaster in the activities room. The maintenance director acknowledged at the time of observations, the use of the power strips for these electrical appliances.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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