CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 09		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		B. WI	NG _		07/19/	/2022	
		1	•	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			INDIANA AVE		
COLONIA	AL NURSING HOM	IE .		CROV	VN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
		paredness Complaint Survey	E 00	000	By submitting the enclosed		
	-	he Indiana Department of			material we are not admitting t		
		ce with 42 CFR 483.73 which			truth or accuracy of any specif	ic	
	included a Compla	int IN00385384 Survey.			findings or allegations. We reserve the right to contest the	2	
	Complaint Number	: IN00385384 was substantiated.			findings or allegations as part		
	No deficiencies rel				any proceedings and submit the		
	Preparedness were				responses pursuant to our	.000	
	1				regulatory obligations. Colonia	al	
	Survey Date: 07/1	9/22			Nursing and Rehab requests the plan of correction be		
	Facility Number: (000360			considered our allegation of		
	Provider Number:				compliance to the Life Safety		
	AIM Number: 100				survey conducted on July 19, 2022.		
	At this Emergency	Preparedness Complaint			2022.		
		ursing Home was found in					
	-	mergency Preparedness					
	_	Medicare and Medicaid					
	Participating Provi	ders and Suppliers, 42 CFR					
	483.73						
	The facility has 55 33.	certified bed and a census of					
	Quality Review co	mpleted on 07/25/22					
K 0000							
Bldg. 01							
bidg. 01	IN00385384 was c	Complaint Number onducted by the Indiana lth in accordance with 42 CFR	K 00	000	By submitting the enclosed material we are not admitting t truth or accuracy of any specif findings or allegations. We reserve the right to contest the	ic	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Complaint Number IN00385384 was substantiated.

TITLE

findings or allegations as part of any proceedings and submit these

(X6) DATE

Any defiency statement 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 disclodays 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Federal/State deficiencies related to the allegation responses pursuant to our were cited K161 and K225. regulatory obligations. Colonial Nursing and Rehab requests that Survey Date: 07/19/22 the plan of correction be considered our allegation of Facility Number: 000360 compliance to the Life Safety Provider Number: 155733 survey conducted on July 19, AIM Number: 100290370 2022. At this complaint investigation, Colonial Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in some of the corridors, some spaces open to the corridors and in some resident rooms. Battery operated smoke detectors are located in some of the corridors, some spaces open to the corridors and in some resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 33. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 07/25/22

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

Page 2 of 11

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

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733			UILDING	INSTRUCTION 01	(X3) DATE COMPL 07/19	LETED	
NAME OF I	PROVIDER OR SUPPLIEF		•		ADDRESS, CITY, STATE, ZIP COD NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0161	NFPA 101						
SS=F		tion Type and Height					
Bldg. 01	_	tion Type and Height					
	2012 EXISTING	ion type and stories meets					
	_	less otherwise permitted by					
	19.1.6.2 through 1						
	19.1.6.4, 19.1.6.5						
	Construc	tion Type					
		(332), II (222) Any number					
	of stories						
		non-sprinklered and					
	sprinklered						
	2 II (111) non-sprinklered	One story					
	non opinicorou	Maximum 3 stories					
	sprinklered						
	3 II (000)	Not allowed					
	non-sprinklered						
	4 III (211)	Maximum 2 stories					
	sprinklered						
	5 IV (2HH)						
	6 V (111)						
	7 III (200)	Not allowed					
	non-sprinklered 8 V (000)	Maximum 1 story					
	sprinklered	Waxiindiii 1 Story					
		s must be sprinklered					
		approved, supervised					
		in accordance with section					
	9.7. (See 19.3.5)						
	Give a brief descr	iption, in REMARKS, of the					
		number of stories, including					
		on which patients are					
		of smoke or fire barriers and					
	I dates of approval	Complete sketch or attach	1	1			ì

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

Page 3 of 11

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
155733		155733			07/19/	/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			NDIANA AVE		
COLONIA	AL NURSING HOM	_			N POINT, IN 46307		
COLONIA	AL NORSING HOW	<u> </u>		CKOWI	N FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the building as appropriate.					
		on and interview, the facility	K 0	161	K161 Building Construction		02/15/2023
	was not an acceptab	ole type of construction as			Type and Height		
	required by NFPA	101 - 2012 edition, Sections			What corrective action(s) will be	be	
	· ·	NFPA 220 - 2012 edition,			accomplished for those reside	nts	
	Section 4.1, 4.1.1 ar	nd Table 4.1.1. This deficient			found to have been affected b	у	
	practice could affec	et all residents.			the deficient practice?		
					An independent company, RT	М,	
	Findings include:				completed an FSES review in		
					2021 and determined all the		
		on with the Administrator on			Interstitial spaces of the		
		.m., observation of the			basement levels and 2nd floor	will	
	-	tructure revealed that the type			require the installation of smol	ke	
		he building was Type V (000),			and heat detectors. Once the		
	_	s two stories. Type V (000) is			smoke detection system is		
	not an acceptable ty	pe of construction for a			installed, it will give these zone	es a	
	two-story existing h	nealthcare building.			passing FSES score, including	9	
					the stairwell. Installation has b	een	
	_	onfirmed by the Administrator			delayed by plan review and		
		very and reviewed at the exit			SafeCare obtaining the neces	sary	
	conference with the	Administrator at 11:40 a.m.			equipment to complete the sm	oke	
					detection system.		
	_	ates to complaint number			Based on FSES scoring,		
	IN00385384.				additional work will need to be	•	
					done to upgrade the smoke		
	3.1-19(b)				detection system. Total Cover	age	
					smoke detection includes the		
					installation of automatic		
					smoke detection in all rooms,		
					halls, storage areas, basemen	its,	
					attics, lofts, spaces above		
					suspended ceilings, and other	•	
					subdivisions and accessible		
					spaces as well as the inside o	f all	
					closets, elevator shafts, enclos		
					stairways, dumb waiter shafts	and	
					chutes (NFPA 72-2010 Section	n	
					17.5.3.1).		
	i		1		The facility hired the company	,	ī

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

Page 4 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2022	
	ROVIDER OR SUPPLIE		119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				SafeCare, to designate areas requiring additional smoke detection coverage. They will upgrade the Fire Alarm System SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Security the design release. There are changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan review not be necessary, per Amy Keat Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire paradditional smoke and heat detectors, carbon monoxide detectors, strobes, pull stationand relay modules with a completion date of February 12023. Once the install has be completed Life safety will be notified to give certification of completed engineer plans. A new FSES was conducted to RTM on June 29, 2022, comppaperwork included (attached parts totaling 28 pages. It inclusives, diagrams, and calculations). SafeCare has attempted to or the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to the needed to the n	also m. Ty for no N will elley of the nel, as 15, een by bleted I in 6 dudes rder ete

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

Page 5 of 11

DEPARTMENT OF HEALTH AND HU	MAN SERVICES		
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF ID PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		le construction ig <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2022	
	PROVIDER OR SUPPLIEI		119	EET ADDRESS, CITY, STATE, ZIP CO 9 N INDIANA AVE OWN POINT, IN 46307	DD .
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) see if the needed parts obtained from a differen We have also contacted Fire Co. to see if they w able to complete the pro sooner, which they were to do (response included definite start date can be this time. They estimate complete the project is s The project is estimated October of 2022 pending availability of parts. The committed to the installa the Complete Smoke De System described above performed by SafeCare. How the facility will iden residents having the pot be affected by the same practice and what correct will be taken? Potentially all residents	can be it vendor. It Koorsen ould be oject e not able d). No e given at id time to 3-4 weeks. It to start in g the facility is ation of etection e to be . tiffy other tential to e deficient ctive action could be
				affected by the alleged of Administrator will review documentation and requireview annually as need Milestones Colonial nursing representative/designeer communicate with vending Care at minimum 2 times month for updates and developments r/t pending Colonial Nursing representative/designeer update of status to ISDH pending project monthly 15th of each month and new development until personal review of the same all the	withe FSES west FSES ded. will or Safe es per og project. will report d of by the with each

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4LFU21 Facility ID: 000360

If continuation sheet Page 6 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (x. 01	(X3) DATE SURVEY COMPLETED 07/19/2022	
		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) complete. Reporting will be in	(X5) COMPLETION DATE
				writing by email and reference Survey ID. ISDH will be notified in writing by email when parts are received by Vendor to complete project. Notified when project begins and when project is complete. What measures will be put into place or what systematic change the facility will make to ensure the deficient practice does not recur. The Maintenance Director will be educated on the proper FSES paperwork for the Life Safety binder. How the corrective action(s) will monitored to ensure the deficien practice will not recur, i.e., what quality assurance program will be put into place? Proper FSES paperwork will be reviewed in QAPI meeting on at least a quarterly basis. By what date the systemic changes will be completed? 2/15/23	y I I es ee ? e be t e
K 0225 SS=E Bldg. 01	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility	K 0225	K225 Stairways and	02/15/2023
	failed to provide an stair enclosures in a 2012 edition, Section	d maintain exit stairs and exit accordance with NFPA 101 - ons 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1,	K 0223	Smokeproof Enclosures What corrective action(s) will be accomplished for those residents found to have been affected by	

FORM CMS-2567(02-99) Previous Versions Obsolete

7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2,

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

found to have been affected by

the deficient practice?

Page 7 of 11

09/29/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, Requesting compliance with 7.7.3, 7.7.3.4, 7.2.2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2 alleged deficiency through the Life and Table 7.2.2.2.1.1 (b). This deficient practice Safety Equivalency granted could affect approximately 6 of the 33 residents. through the FSES once all required work in the FSES is Findings include: complete and a passing score is achieved. These stairs would only Based on observations with the Administrator on be used in an emergency 07/19/22 at 11:30 a.m., the following was situation, i.e. fire evacuation and discovered: do reach the sidewalk downstairs a) the exit stair by room 201 was not enclosed in for egress to outside the building. fire rated construction. The door to the stair did An independent company, RTM, not have fire resistance rating. completed an FSES review in b) the stair by room 201 consisted of metal open 2021 and determined all the grate walking surfaces. The landing and all of the Interstitial spaces of the stair treads were metal open grate where there was basement levels and 2nd floor will 1/4-inch piece of metal and a 1-inch gap between require the installation of smoke the 1/4-inch metal pieces. This building is a and heat detectors. Once the healthcare occupancy. smoke detection system is c) the stair by room 201 continued down from the installed, it will give these zones a upper landing 24 risers to the bottom of the stair passing FSES score, including without an intermittent landing. The the stairwell. Installation has been approximately 15-foot distance exceeded the delayed by plan review and allowable maximum 12-foot distance between SafeCare obtaining the necessary equipment to complete the smoke d) the stair by room 201 only had a 30-inch clear detection system. width and not the required minimum 36-inch clear Based on FSES scoring. width. additional work will need to be done to upgrade the smoke The measurements from the 07/12/21 federal detection system. Total Coverage monitoring survey were used at this survey. The smoke detection includes the Administrator confirmed the measurements were installation of automatic accurate at the time of discovery and during the smoke detection in all rooms. exit conference at 11:40 a.m. halls, storage areas, basements, attics, lofts, spaces above

FORM CMS-2567(02-99) Previous Versions Obsolete

IN00385384.

3.1-19(b)

This federal tag relates to complaint number

Event ID:

4LFU21

Facility ID: 000360

If continuation sheet

suspended ceilings, and other

closets, elevator shafts, enclosed stairways, dumb waiter shafts and

subdivisions and accessible spaces as well as the inside of all

Page 8 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CE

PRINTED: 09/29/2022 FORM APPROVED NO. 0938-039

STREET, STEEL STREET,	WILL BERTICES		1 ORM MITH
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A RUILDING 01	COMPLETED

		155733	B. WING	ADDRESS, CITY, STATE, ZIP COD	07/19/2022
	ROVIDER OR SUPPLIER AL NURSING HOMI		119 N I	NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	chutes (NFPA 72-2010 Sect 17.5.3.1).	DATE
				The facility hired the compains SafeCare, to designate area requiring additional smoke detection coverage. They will upgrade the Fire Alarm Syst SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Securithe design release. There are changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan revien to be necessary per Amy kat Indiana State Department Health (emails attached). SafeCare will install/replace following items: a new fire padditional smoke and heat detectors, carbon monoxide detectors, strobes, pull static and relay modules with a completion date of December 2022. Once the install has be completed Life safety will be notified to give certification completed engineer plans. A new FSES survey was conducted on 6/29/22 by RT completed paperwork included.	ill also dem. frity for the no the will Kelley the fanel, for the fanel, fo
				SafeCare has attempted to on the necessary parts to compute the project but the parts are backordered. Colonial is	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21 Facility ID: 000360

If continuation sheet

Page 9 of 11

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

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/19/2022
	PROVIDER OR SUPPLIE		119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	attempting to get a list of the needed parts from SafeCare it see if the needed parts can be obtained from a different vend We have also contacted Koon. Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No defining start date can be given at this time. They estimated time to complete the project is 3-4 were The project is estimated to stain October of 2022 pending the availability of parts. The facility committed to the installation of the Complete Smoke Detection System described above to be performed by SafeCare. This give the building a passing soon in the FSES. Milestones Colonial nursing representative/designee will communicate with vendor SafeCare at minimum 2 times per month for updates and developments r/t pending project complete. Reporting will be in writing by email and reference Survey ID. ISDH will be notified in writing email when parts are received.	e dor. sen e ite ite eeks. art e y is f on e will ore e ect. eport e each is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4LFU21

Facility ID: 000360

Vendor to complete project.

If continuation sheet

Page 10 of 11

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

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/19/2022
	PROVIDER OR SUPPLIER AL NURSING HOME	119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307	
(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 APPROPRIA DEFICIENCY) Notified when project begins a	DATE
			Notified when project begins a when project is complete. How the facility will identify of residents having the potential be affected by the same deficipractice and what corrective a will be taken? Potentially 6 residents on the upper floor could be affected. above remedies cover all potentially stairways and smokeproof enclosures. What measures will be put into place or what systematic characteristic forms the facility will make to ensure deficient practice does not reconstructed on the proper FSES paperwork for the Life Safety binder. How the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance program will put into place? Proper FSES paperwork will be reviewed in QAPI meeting on least a quarterly basis. By what date the systemic changes will be completed?	ther to to tient ction The ential or orges the eur? be will be tent at Il be

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4LFU21 Facility ID: 000360 If continuation sheet Page 11 of 11