

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 09/09/2016
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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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(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
K 0000 Bldg. 01	<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: 09/09/16</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</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 alarm system with hard wired smoke detection in the corridors, spaces open to</p>	K 0000	<p>This plan of correction is to serve as Colonial Nursing & Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Colonial Nursing & Rehabilitation Center or it's 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 or admission of the survey allegations.</p>	

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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K 0015 SS=D Bldg. 01	<p>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 completed on 09/19/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish on the walls in 1 of 1 Administrative room closet had a flame spread rating of Class A, Class B, or Class C. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes</p>	K 0015	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-015 / SS-D: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Deficient practice will not affect any residents since affected area is in an area one level below patient occupancy. This</p>	10/09/2016

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	<p>in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 12:04 p.m., the Administrative office closet had wood paneling on the walls. Based on interview at the time of observation, the Maintenance Director</p>		<p>deficiency could affect staff only. Administrative office closet wood paneling will be removed and replaced with 5/8" drywall meeting flame retardant requirements and repainted.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: No residents are affected by existing practice.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Once paneling is removed and new drywall installed/painted, the deficient practice will not occur.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: The corrective action is one time and final thus requiring no ongoing monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) By what date will the systemic changes be completed: Removal of closet wood paneling and drywall replacement/painting will be completed by 10-9-2016.</p>	

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K 0017 SS=E Bldg. 01	<p>was unable to provide documentation for a flame spread classification of Class A, B, or C.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck 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 corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 2nd floor Dining room linen closet and 1 of 1 "Closet near Administrative office" was separated from the corridors by a partition capable of resisting the passage of smoke 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</p>	K 0017	<p>2016 LSC POC K015</p> <p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-017 / SS-E: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A smoke detector will be installed in the 2nd floor dining room linen closet and closet near administrative office (storage for office supplies). Both smoke detectors will be connected to the</p>	10/09/2016

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	<p>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 an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and up to 35 residents</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:30 a.m. then again at 12:05 p.m., the 2nd floor Dining room linen closet and "Closet near Administrative office" contained a closet door that was not fully smoke resistive at the top which was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the rooms were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>automatic smoke detection system.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Staff assigned to work in that area plus all residents on 2nd floor near the dining room linen closet could be affected and staff working in/around the lower level administrative closet area could be affected.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Smoke detectors will be installed in 2nd floor dining room linen closet and supply closet near administrative area.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Dir. Of Maintenance/Designee will conduct semi-annual checks of smoke detectors to insure operational functioning and report to QA Committee for next two quarterly QA meetings.</p> <p>(E) By what date will the systemic changes be completed: Installation of new smoke detectors will be completed by 10-9-2016.</p>				

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K 0020 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 vertical openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient</p>	K 0020	<p>LSC 2016 POC K017</p> <p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-020 / SS-E: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Basement storage stairway door will be adjusted to close properly by replacing door closer.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Described area is not patient area but used by vendors and staff only.</p>	10/09/2016

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K 0029 SS=E Bldg. 01	<p>practice could affect staff and at least 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:52 a.m., the Basement storage stairway door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic</p>		<p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Basement storage stairway door will be configured with new door closer to insure fire door assembly has required one hour fire resistance.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Installation of new door closer will be completed by 10-9-2016.</p> <p>LSC 2016 POC K020</p>	

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	<p>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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 2nd floor soiled linen room, a hazardous area, failed to positively latch into the frame. This deficient practice could affect staff and up to 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 10:51 a.m., the 2nd floor soiled linen corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Furnace room, a hazardous area, failed to positively latch into the frame. This deficient practice</p>	K 0029	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016</p> <p>Summary of Deficiency Tags:</p> <p>1. K-029 / SS-E:</p> <p>(A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 2nd floor soiled linen corridor door will be adjusted to close properly by replacing door closer.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All patients on 2nd floor and staff assigned have the potential to be affected by the deficient practice.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: 2nd floor soiled linen corridor door will be configured with new door closer to insure fire door assembly has required one hour fire resistance.</p>	10/09/2016

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K 0038 SS=F Bldg. 01	<p>could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:57 a.m., the Basement Furnace room corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 NW Liberty exit had a code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the</p>	K 0038	<p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Installation of new door closer will be completed by 10-9-2016.</p> <p>LSC 2016 POC K029</p> <p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-038 / SS-F: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p>	10/09/2016

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	<p>egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 between 10:54 a.m. to 11:34 a.m., the following entrance/exit doors were held in the locked position with a magnetic hold down device. Furthermore, the following exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. No codes were posted at the entrance/exit doors:</p> <ul style="list-style-type: none"> a) C Hall 3rd floor b) Nurses' station 2nd floor c) Dining room 2nd floor d) C Hall Puzzle room e) Front Entrance <p>Based on an interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. Additionally, the Maintenance</p>		<p>Exit codes were posted at the entrance/exit doors in the following locations: C-hall 3d floor; nurses' station – 2nd floor; dining room 2nd floor; C-hall puzzle room; front entrance.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents and staff assigned have the potential to be affected by the deficient practice. Codes will be placed at each entrance/exit door.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Director of Maintenance replaced exit code signs at each referenced location on 9-10-16.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Exit code signs were installed/completed by 9-10-2016.</p>	

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K 0039 SS=E Bldg. 01	<p>Director was unable to confirm a clinical need for specialized security measures for the residents.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation, the facility failed to ensure 1 of 1 2nd floor Nurses' station exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect staff and at least 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:03 a.m., the access corridor near the Nurses' station corridor wall width</p>	K 0039	<p>LSC 2016 POC K038</p> <p>LSC 2016 POC K029</p> <p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-039/SS-E: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator and Director of Maintenance will design a plan to reconstruct the nursing station adjacent to the corridor to accommodate the required 48" clear unobstructed exit corridor width.</p>	10/23/2016

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	<p>measured 45 inches. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents and staff assigned have the potential to be affected by the deficient practice. Plan is to widen exit corridor at the nurses' station to accommodate 48 inch width as required..</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A construction/renovation design will be developed with corporate oversight and outside vendor contract work to reconfigure the nurses' station to accommodate the 48 inch width as required.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: A design planning meeting will be coordinated by Administrator, corporate maintenance director and corporate construction</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 09/09/2016
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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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K 0048 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1	K 0048	<p>company for October 4, 2016. Final completion date of this project will be subject to contractor scheduling and facility requests extension of this project completion to October 23, 2016.</p> <p>LSC 2016 POC K039</p> <p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016</p>	10/23/2016

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 09/09/2016
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	<p>of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Director on 09/09/16 at 11:29 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation of the 2nd floor corridor doors did not have drywall above the drop ceiling to the ceiling. Based on interview at the time of</p>		<p>Summary of Deficiency Tags:</p> <ol style="list-style-type: none"> 1. K-048/SS-E: <ol style="list-style-type: none"> (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator and Director of Maintenance will design a plan to complete the corridor fire doors on 2nd floor with installation of dry wall system above the drop ceiling. (B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents and staff assigned have the potential to be affected by the deficient practice. Plan is to install dry wall above the drop ceiling on the 2nd floor corridor fire doors. (C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A construction/renovation design will be developed with corporate oversight and outside vendor contract work to install dry wall above the drop ceiling on the 2nd floor corridor fire doors. (D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one 	

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	<p>observation, the Maintenance Director acknowledged the wall is not a complete barrier.</p> <p>3.1-19(b)</p>		<p>time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: A design planning meeting will be coordinated by Administrator, corporate maintenance director and corporate contractor for October 4, 2016. Final completion date of this project will be subject to contractor scheduling and is projected for completion October 23, 2016.</p> <p>LSC 2016 POC K048</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 09/09/2016
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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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 8 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of titled "Fire Drill Record" with the Maintenance</p>	K 0050	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-050/SS-C: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator and Director of Maintenance will design a Fire Drill Record form to include verification of transmission of the fire alarm signal to the monitoring station. Revision to show date, time and person responding to the transmission at the monitoring station.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents</p>	10/09/2016	

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 09/09/2016
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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	<p>Director on 09/09/16 at 9:57 a.m., February, March, April, May, June of 2016 and September, October, November of 2015 failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>and staff assigned have the potential to be affected by the deficient practice. Plan is to redesign the Fire Drill Record to show the verification contact information (see Atch. 1)</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A revised form will be designed/implemented by Director of Maintenance and Administrator which shows verification of transmission of the fire alarm signal to the monitoring station.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: A revised form has been completed (see Atch. 1) and will be in place for October fire drill records by Oct. 9, 2016.</p> <p>LSC 2016 POC K050</p>		

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K 0051 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to</p>			

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	<p>notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the 2nd floor Dining Room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:05 a.m., the 2nd floor Dining room had a smoke detector located twelve inches away from an HVAC vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain and secure 1 of 1 fire alarm systems in accordance with the requirements of NFPA 101 - 2000 edition, Sections 20.3.4.1, 9.6 and</p>	K 0051	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-051/SS-E: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The 2nd floor dining room smoke detector will be relocated to proper distance of more than 3.5 ft away from HVAC vent. Also the electrical panel near Room 121 will be locked and the breaker for the Fire Alarm Control Panel will be relocated to another breaker box.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents and staff assigned have the potential to be affected by the deficient practice. Plan is to relocate smoke detector and relocate breaker for Fire Control Panel into another breaker box and lock the existing breaker panel box near Room 121.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does</p>	10/09/2016

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 09/09/2016
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	<p>9.6.1.4, as well as, NFPA 72 - 1999 edition, Sections 7-3.1, 7-3.2 and 7-5.2.2. This deficient practice could affect staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/16 at 11:18 a.m., the electrical panel located in the hallway near resident room 121 contained the breaker for the Fire Alarm Control Panel. The door to the panel nor the breaker itself was locked. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>not recur: Plan is to relocate smoke detector away from HVAC vent and relocate breaker for Fire Control Panel into another breaker box and lock the existing breaker box near Room 121.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Contractor work on the relocations and rewiring for the breaker box will be completed by Oct. 9, 2016.</p> <p>LSC 2016 POC K051</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 09/09/2016
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K 0062 SS=D Bldg. 01	<p>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</p> <p>Based on observation and interview, the facility failed to maintain the ceiling construction around 1 of 1 sprinklers. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 1999 edition, Section 5-5.4.1, states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 09/09/16 at 12:05 p.m., the "Closet near Administrative office" was missing 4 of 4 ceiling tiles. Based on interview at the time of observation, the Maintenance</p>	K 0062	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags: 1. K-062/SS-D: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The closet near Administrative Office with four (4) missing ceiling tile will be replaced with new drywall ceiling.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All staff assigned to work in the administrative area could be affected by the deficient practice. Plan is to replace four (4) missing ceiling tile with new drywall ceiling.</p>	10/09/2016

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	Director acknowledged the aforementioned condition. 3.1-19(b)		(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Plan is to replace four (4) missing ceiling tile with new drywall ceiling. (D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting. (E) What date will the systemic changes be completed: Contractor work on the replacement of ceiling tile with new drywall ceiling will be completed by Oct. 9, 2016. LSC 2016 POC K062	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2016
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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K 0074 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 window curtain in the C Hall Puzzle room was</p>	K 0074	Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016 Summary of Deficiency Tags:	10/09/2016	

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 09/09/2016
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	<p>flame retardant. This deficient practice could affect staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 09/09/16 between 10:40 a.m. and 12:19 p.m., there was a window curtain in the C Hall Puzzle room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed there was no documentation was available for review.</p> <p>3.1-19(b)</p>		<p>1. K-074/SS-E:</p> <p>(A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Director of Maintenance will attempt to secure proper documentation on flame spread rating for the window curtain in C-hall puzzle room or remove unauthorized curtain with a curtain validated with one hour flame retardation rating as required.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents on C-hall have potential to be affected by the deficient practice. Plan is to validate current material on curtain as meeting flame spread criteria or simply replace entire curtain.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Plan is to secure proper flame spread documentation or replace entire curtain with one meeting flame spread requirements.</p> <p>(D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance</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 09/09/2016
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K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in		<p>program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Verification of existing curtain flame spread documentation or replacement of entire curtain to be completed by Oct. 9, 2016.</p> <p>LSC 2016 POC K074</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 09/09/2016
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	<p>accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, 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 affects staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 09/09/16 at 11:37 a.m. then again at 12:07 p.m., a surge protector was powering a refrigerator in the 2nd floor Chart room. Then again, a surge protector was powering another surge protector powering the facility's Internet in the Business office. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0147	<p>Colonial Nursing & Rehab Center Life Safety Code (LSC) Survey - September 9, 2016</p> <p>Summary of Deficiency Tags:</p> <p>1. K-0147/SS-E: (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Director of Maintenance has removed the refrigerator from the 2nd floor chart room. The facility internet connectivity will be reconfigured with a separate battery pack.</p> <p>(B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents and staff have potential to be affected by the deficient practice. Plan is to remove refrigerator from chart room and install separate battery for facility internet connections.</p> <p>(C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Plan is to remove refrigerator from chart room and install separate battery for facility internet connections.</p> <p>(D) How the corrective action(s) will be monitored to ensure the</p>	10/09/2016

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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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			<p>deficient practice will not recur, i.e. what quality assurance program will be put into place, and: Corrective action is one time and final fix thus requiring no ongoing QA monitoring. Status of completion will be presented at next scheduled QA meeting.</p> <p>(E) What date will the systemic changes be completed: Director of Maintenance has relocated the refrigerator to a separate outlet in the chart room. New battery for facility internet connectivity will be installed and completed by Oct. 9, 2016.</p> <p>LSC 2016 POC K147</p>	

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

PRINTED: 10/07/2016
FORM APPROVED
OMB NO. 0938-0391

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