| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING _____ B. WING _____ | C 01/05/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00423561.<br><br>Complaint IN00423561 - No deficiencies related to the allegations are cited.<br><br>Survey dates: January 5, 2024<br><br>Facility number: 000360<br>Provider number: 155733<br>AIM number: 100290370<br><br>Census Bed Type:<br>SNF/NF: 31<br>Total: 31<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 22<br>Other: 8<br>Total: 31<br><br>Colonial Nursing Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00423561.<br><br>Quality review completed on 1/9/24. | F 000 | | |

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