PRINTED: 06/10/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING COM		COMPL	ETED
		155733	B. W	NG		05/24/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NDIANA AVE		
COLONIA	AL NURSING HOMI	E			N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 APPROPRIA'	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Diag.	An Emergency Prer	paredness Survey was	E 00	000	By submitting the enclosed		
		diana Department of Health		<i>,</i> 00	material we are not admitting t	he	
	in accordance with	-			truth or accuracy of any specif		
	accordance with				findings or allegations. We		
	Survey Date: 05/24	-/2021			reserve the right to contest the	:	
		-			findings or allegations as part		
	Facility Number: 0	00360			any proceedings and submit the		
	Provider Number:				responses pursuant to our		
	AIM Number: 1002	290370			regulatory obligations. Colonia	al	
					Nursing and Rehab requests		
	At this Emergency I	Preparedness survey,			the plan of correction be		
	Colonial Nursing H	ome was found in substantial			considered our allegation of		
	compliance with En	nergency Preparedness			compliance effective June 23,		
	Requirements for M	ledicare and Medicaid			2021 to the Life Safety survey		
	Participating Provid	lers and Suppliers, 42 CFR			conducted on May 24, 2021 a	nd	
	483.73				request paper compliance.		
	-	certified beds. At the time of					
	the survey, the cens	us was 38.					
	Quality Review con	npleted on 05/27/21					
E 0039	403.748(d)(2), 416	6.54(d)(2), 418.113(d)(2),					,
SS=C	441.184(d)(2), 482	2.15(d)(2), 483.475(d)(2),					
Bldg		102(d)(2), 485.625(d)(2),					
	485.68(d)(2), 485.	727(d)(2), 485.920(d)(2),					
	486.360(d)(2), 491	1.12(d)(2), 494.62(d)(2)					
	EP Testing Requir	rements					
	§416.54(d)(2), §41	18.113(d)(2), §441.184(d)					
	(2), §460.84(d)(2),						
		33.475(d)(2), §484.102(d)					
	(2), §485.68(d)(2),						
		185.920(d)(2), §491.12(d)					
	(2), §494.62(d)(2).						
	-	6.54, CORFs at §485.68, ons" under §485.727,					
	-						

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733			UILDING	NSTRUCTION	COMP	LETED 1/2021	
	PROVIDER OR SUPPLIEI		•	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APF	JLD BE	(X5) COMPLETION
TAG	CMHCs at §485.9	20, RHCs/FQHCs at		TAG	DEFICIENCY)		DATE
	(2) Testing. The [i exercises to test the content of the content o	RD Facilities at §494.62]: facility] must conduct he emergency plan ility] must do all of the					
	community-based (A) When a community accessible, co	full-scale exercise that is every 2 years; or nunity-based exercise is onduct a facility-based e every 2 years; or					
	(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its						
	facility-based fund the onset of the a	nmunity-based or individual, ctional exercise following ctual event. ditional exercise at least					
	full-scale or functi paragraph (d)(2)(i	•					
	limited to the follo (A) A second full-	ay include, but is not wing: scale exercise that is or individual, facility-based					
	functional exercis (B) A mock disast (C) A tabletop exe	e; or er drill; or ercise or workshop that is					
	discussion using a clinically-relevant a set of problem s	emergency scenario, and tatements, directed					
	to challenge an el (iii) Analyze the [f maintain docume	pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733		ľ í	JILDING	NSTRUCTION	(X3) DATE COMPL 05/24/	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	119 N II	NDDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN 46307	<u>'</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) rgency plan, as needed.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	*[For Hospices at (2) Testing for hose the patient's home conduct exercises at least annually. following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice of man-made emerging activation of the eliast exempt from en full scale community following the onse (ii) Conduct an activation of the eliast exempt from en full scale community following the onse (iii) Conduct an activational exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop excelled by a facilitator discussion using a clinically-relevant a set of problem singular exercises (B) Testing for hose care directly. The	418.113(d):] spices that provide care in spices that provide care in to test the emergency plan. The hospice must do the full-scale exercise that is every 2 years; or unity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires mergency plan, the hospital gaging in its next required ity-based exercise or eased functional exercise to f the emergency event. Iditional exercise every 2 ever the full-scale or event paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group in narrated, emergency scenario, and tatements, directed bared questions designed mergency plan.					
	exercises to test th	ne emergency plan twice					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	ì í	UILDING	NSTRUCTION	(X3) DATE COMPI 05/24	LETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE	
	(i) Participate in a exercise that is considered that is considered that is considered that is considered that may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extractilitator that including a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the high maintain documer exercises, and emergency semester that including the community of the co	dditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared						
	§482.15(d), CAHs (2) Testing. The [I conduct exercises twice per year. TI must do the follow	s at §485.625(d):] PRTF, Hospital, CAH] must s to test the emergency plan ne [PRTF, Hospital, CAH]						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI 05/24	LETED
	PROVIDER OR SUPPLIER		STREE 119 N CRO			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	(A) When a common to accessible, confacility-based functions are mergency that responding in its new community based functional exercise emergency event. (ii) Conduct are exercise or and the limited to the follow (A) A second full-community-based facility-based functionally-based facility-based functions (B) A money (C) A tabletop is led by a facilitate discussion, using a clinically-relevant a set of problem is messages, or prepto challenge an error (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded. *[For PACE at §46 (2) Testing. The Pacced conduct exercises at least annually. The participate in a exercise that is confidence in a exercise that is confidence.	dospital, CAH] stual natural or man-made quires activation of the the [facility] is exempt from kt required full-scale or individual, facility-based of following the onset of the an [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed bared questions designed energency plan. The [facility's] response to simentation of all drills, and emergency events sility's] emergency plan, as 60.84(d):] ACE organization must to test the emergency plan The PACE organization				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION		LETED L/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	not accessible, co facility-based functional exercises of this section is country-based functional exercises of this section is country-based based functional exercise functional exercises of this section is country-based based functional exercise functional exercises, and exercises, and emitted the paction of the paction o	nduct an annual individual, tional exercise; or speriences an actual and emergency that a of the emergency plan, apt from engaging in its next community based or cased functional exercise to fithe emergency event. In additional exercise every the year the full-scale or equider paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or the dill; or exercise or workshop that is and includes a group an anarrated, emergency scenario, and tatements, directed cared questions designed mergency plan. ACE's response to and station of all drills, tabletop dergency events and revise gency plan, as needed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		155733	B. W	ING		05/24	/2021
NAME OF F			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C .		119 N II	NDIANA AVE		
COLONIA	AL NURSING HOM	E		CROWN	N POINT, IN 46307		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)	BE.	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	facility-based fund	<u> </u>					
	1	ility] facility experiences					
	` <i>'</i>	or man-made emergency					
		ration of the emergency					
	I	lity is exempt from					
	I -	required a full-scale					
		or individual, facility-based					
	· ·	e following the onset of the					
	emergency event.						
	(ii) Conduct an ad	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	or an individual, facility					
	based functional e	exercise; or					
	(B) A mock disas						
		ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using						
		emergency scenario, and					
		statements, directed					
		pared questions designed					
	to challenge an er						
	_ ` ' -	LTC facility] facility's					
		maintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	S483 475(d)]·					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						
	"	n annual full-scale exercise					
	that is community						
		nunity-based exercise is					
		onduct an annual individual,					
		ctional exercise; or.					
	1	experiences an actual					
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		155733	B. W	ING		05/24	/2021
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF F	PROVIDER OR SUPPLIEF	{		119 N II	NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
	<u> </u>		1	<u> </u>	- ,		77.5
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ade emergency that					
		n of the emergency plan,					
		mpt from engaging in its					
	1	scale community-based or					
	I	based functional exercise					
		et of the emergency event.					
	1 ' '	ditional annual exercise					
	· ·	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
	· ·	and includes a group					
	discussion, using						
	I -	emergency scenario, and					
	-	tatements, directed					
		pared questions designed					
	to challenge an er						
	1 ' '	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's emei	rgency plan, as needed.					
	*[=	24.4001					
	*[For HHAs at §48	-					
	. , , ,	e HHA must conduct					
		he emergency plan at					
	· ·	e HHA must do the					
	following:	full-scale exercise that is					
	community-based	, or ommunity-based exercise					
	, ,	conduct an annual					
		based functional exercise					
	every 2 years; or.	Dascu Iuliciioliai Excloise					
	1 -	A experiences an actual					
		A experiences an actual adde emergency that					
	-	of the emergency plan,					
	i ille nna is exemp	ot from engaging in its next					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPL 05/24 /	ETED
	PROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN 46307	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	required full-scale individual, facility I following the onse (ii) Conduct an adyears, opposite the functional exercise of this section is coinclude, but is not (A) A second community-based facility-based funcional exercise is led by a facilitate discussion, using clinically-relevant a set of problem s messages, or prepto challenge an er (iii) Analyze the HI maintain documer exercises, and em the HHA's emerged *[For OPOs at §48 (d)(2) Testing. The exercises to test the OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency plan. I actual natural or mergency plan.	community-based or passed functional exercise of the emergency event. ditional exercise every 2 ever the full-scale or every 2 ever the full-scale or event that may limited to the following: full-scale exercise that is or an individual, tional exercise; or saster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed mergency plan. HA's response to and station of all drills, tabletop hergency events, and revise ency plan, as needed. 36.360] 6 OPO must conduct the emergency plan. The				

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		l í	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:				COMPL	
		155733	B. WI	NG		05/24/	2021
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHOO) CROSS-REFERENCED TO THE APF DEFICIENCY)		TE	(X5) COMPLETION DATE
	of the emergency (ii) Analyze the Of- maintain documer exercises, and em the [RNHCI's and as needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCI must do the (i) Conduct a paper at least annually. It group discussion in narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCI's emer Based on record rev facility failed to core emergency plan at I ICF/IID facility mu (i) Participate in an that is community-la. When a commun accessible, conduct facility-based funct b. If the ICF/IID facility nutural or man-mad activation of the em facility is exempt for required full-scale is individual, facility- exercise for 1 year actual event.	event. PO's response to and nation of all tabletop nergency events, and revise OPO's] emergency plan, 3.748]: Part RNHCI must conduct the emergency plan. The ne following: Per-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a relevant emergency plan. Perelevant emergency plan. NHCI's response to and nation of all tabletop nergency events, and revise regency plan, as needed. Priew and interview, the nation exercises to test the east twice per year. The st do the following: annual full-scale exercise passed; or ity-based exercise is not an annual individual,	E 00		E039- EP Testing Requireme What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? No residents were harmed by alleged deficient practice. How the facility will identify other residents having the potential be affected by the same deficient practice and what corrective action will be taken? All residents had the potential be harmed by alleged deficient practice. An audit of emergence procedure binders was done be the Administrator facility wide the surrection that all are up to date.	the to ent to tto tt	06/23/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	<u></u>	COMPLETED	
		155733	B. W	ING		05/24/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
001.01		_			NDIANA AVE		
COLONIA	AL NURSING HOM	E		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROVIDED'S DEAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	include, but is not li	mited to the following:			There are 9 binders accessible	e to	
	a. A second full-sca	e e			staff/residents/visitors through	out	
		r an individual, facility-based			the building. It was reviewed ir		
	functional exercise.				Staff as recently as 5/18/21.		
	b. A mock disaster of	drill: or			What measures will be put into		
		se or workshop that is led by			place or what systematic		
	-	ludes a group discussion led			changes the facility will make t	in	
	by a facilitator, usin				'	٠	
		mergency scenario, and a set			ensure the deficient practice		
	•	nts, directed messages, or			does not recur?		
	*	designed to challenge an			A minimum of 2 full scale drills	or	
	emergency plan.	designed to chancinge an			tabletop exercises will be		
		F/IID facility's response to			completed over the next year.		
		• •			The facility is a member of		
		nentation of all drills, tabletop		District 1 Emergency			
		gency events, and revise the		Management Committee. We will			
		nergency plan, as needed in		to			
		CFR 483.475(d)(2). This	work in conjunction with them to complete any necessary				
	deficient practice co	ould affect all occupants.			exercises. The facility has		
	T. 1 1 1				created a binder of relevant dr	ille	
	Findings include:				based on our Hazard		
					Vulnerability Assessment that		
	-	w with the Maintenance					
		021 at 10:45 a.m. the			will be used as a resource for		
		cumentation for it's response			drills.		
		ublic Health Emergency,			How the corrective action(s) w	ill	
		provide documentation of an			be monitored to ensure the		
	additional exercise				deficient practice will not recur	,	
		lness plan. Based on			i.e., what quality assurance		
		e of record review, the			program will be put into place?	,	
		or agreed that they only have			The emergency management		
	documentation for t	he response to the			binder will be reviewed at leas	t	
	COVID-19 Public I	Health Emergency, and could			quarterly at the QA Meeting to		
	not provide docume	ntation of an additional			ensure that it is up-to-date and		
	exercise of choice w	vithin the most recent year.			that plans for drills are being		
					discussed.		
	This deficient practi	ice was reiewed with the			By what date the systemic		
	Administrator at the				changes will be completed?		
					6/23/21		
					0.20,21		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u> CO		COMPL	COMPLETED	
		155733	B. W	B. WING		05/24/	/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			NDIANA AVE			
COLONI	AL NURSING HOM	1 E			N POINT, IN 46307			
COLOINI	AL NURSING HUIV	'IC		CROW	N POINT, IN 46307			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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 OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K 0000								
Bldg. 01								
		e Recertification and State	K 0	000	By submitting the enclosed			
		were conducted by the Indiana			material we are not admitting			
	-	alth in accordance with 42			truth or accuracy of any specif	ic		
	CFR 483.90(a).				findings or allegations. We			
					reserve the right to contest the			
	Survey Date: 05/2	4/2021			findings or allegations as part			
					any proceedings and submit the	nese		
	Facility Number: (responses pursuant to our			
	Provider Number:				regulatory obligations. Coloni			
	AIM Number: 100)290370			Nursing and Rehab requests	that		
	A. d. T.C.C.C.				the plan of correction be			
		Code survey, Colonial			considered our allegation of			
	-	s found not in compliance with			compliance effective June 23,			
	Requirements for I	-			2021 to the Life Safety survey			
		d, 42 CFR Subpart 483.90(a),			conducted on May 24, 2021 a	na		
		ire and the 2012 edition of the			request paper compliance.			
		ection Association (NFPA) ode (LSC), Chapter 19,						
		are Occupancies and 410 IAC						
	16.2.	ire Occupanicies and 410 IAC						
	10.2.							
	This facility is a tw	vo story fully sprinklered						
		ed to be Type V (111)						
	-	a lower level located in the						
		itions and updates made prior						
		The facility has a fire alarm						
		vired smoke detection in the						
		pen to the corridors, and C						
		lent rooms. All other						
	resident rooms are	equipped with battery						
		tectors. The building is						
	partially protected	by a Natural Gas fueled 12kW						
		lity has the capacity for 55						
		ds and had a census of 38 at						
	the time of this sur	vey.						
	All areas where the	e residents have customary						
I	1		1		i .		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>			COMPLETED	
		155733	B. WING 05/24/2021			2021	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
COLONIA	AL NURSING HOMI	E	119 N INDIANA AVE CROWN POINT, IN 46307				
COLOINIA	AL NURSING HOM	<u> </u>		CROW	N FOINT, IN 40307		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	access and areas pro	oviding facility services were					
	sprinklered.						
	Quality Review completed on 05/27/21						
14 00 45	NEDA 404						
K 0345	NFPA 101	. T K					
SS=D	Fire Alarm System	ı - ı esting and					
Bldg. 01	Maintenance	Tooting and					
	Fire Alarm System Maintenance	1 - Testing and					
		m is tosted and maintained					
	-	n is tested and maintained n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		n and Signaling Code.					
		n acceptance, maintenance					
	and testing are rea						
	9.6.1.3, 9.6.1.5, N	_					
		on the facility failed to	K 0	2.45	K345 Fire Alarm System-		06/23/2021
		ske detectors in the boiler	KU	343	Testing and Maintenance		00/23/2021
		with NFPA 72, National Fire			What corrective action(s) will be	ا ا	
		g Code, Section 17.4.4.			accomplished for those reside		
	-	s that initiating devices shall			found to have been affected by		
		endently of their attachment			the deficient practice?	<i>'</i>	
		ctors. This deficiency			No residents were harmed by	tho	
	affects staff only.				I -		
	,				alleged deficient practice. The		
	Findings include:				identified detector was properly	-	
	C				secured to the base independe	ent	
	During a facility tou	ir with the Maintenance			of its attachments.		
	-	021 at 10:55 a.m. a smoke			How the facility will identify oth		
	detector in the boile	erroom was supported only by			residents having the potential		
		sed on interview at the time			be affected by the same defici	ent	
	of observation, the I	Maintenance Director agreed			practice and what corrective	ļ	
		ctor was supported only by			action will be taken?	ļ	
	the conductors.				A facility wide audit of smoke	ļ	
					detectors was completed by th		
	This deficiency was	reviewed with the			Maintenance Director to ensur		
	Administrator at the	e time of exit.			that all were properly attached		
					their base and any deficiencies	3	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	e survey Pleted 24/2021
	ROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZI NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	3.1-19(b)			were immediately combated with the system changes the facility ensure the deficient does not recur? An inservice was do Director of Maintena proper securing of sidetectors. How the corrective as be monitored to ensure the deficient practice will i.e., what quality assigned program will be put if A performance improved the system of the propers of the public of the program will be put if and then bi-weekly find then bi-weekly find the propers of the public of the province of the public of the province of the public of the publi	be put into matic will make to practice ne with the ince on the moke action(s) will ure the Il not recur, surance into place? ovement tool I audit 5 ctors in the for 3 months for an Above audit in the QA interly. stemic	
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing or and standpipe systems red, and maintained in IFPA 25, Standard for the rg, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a readily available. system last checked				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733		A. BUILDING B. WING	01	COMPLETED 05/24/2021			
COLONI	PROVIDER OR SUPPLIER	E	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE		
	b) Who provided c) Water system Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record reversacility failed to masprinkler systems in "Inspection, Testing Water-Based Fire P. 5.3.4 which states the solutions in antifree measuring the specifor refractometer and necessary. This deall residents, staff and Findings include: During record revied Director on 05/24/2 sprinkler inspection and dated 02/09/202 antifreeze was tested Fahrenheit. The fact documentation that Based on interview the Maintenance Diantifreeze was out of geography.	system test Supply source RKS information on non-required or partial r system. and NFPA 25 riew and interview, the intain 1 of 1 automatic accordance with NFPA 25, and Maintenance of rotection Systems", Section nat The freexing point of ze shall be tested annually by fic gravity with a hydrometer diadjusting the solutions if ficient practice could affect and visitors. We with the Maintenance of the dat 9 and 11 degrees reliable to provide the antifreeze was adjusted. The dat the dat 9 and 11 degrees rector agreed that the dat frange for the facility's ang was reviewed with the day was reviewed with the day was reviewed with the day and so rector agreed that the day and so rector agreed that the day and so rector agreed that the day was reviewed with the day	K 0353	K353- Sprinkler system- Maintenance and Testing What corrective action(s) will accomplished for those reside found to have been affected the deficient practice? No residents were harmed be deficient practice. How the facility will identify or residents having the potentiable affected by the same definity practice and what corrective action will be taken? All residents had the potentiable harmed by the alleged deficiency in colder weather What measures will be put in place or what systematic changes the facility will make ensure the deficient practice does not recur? The Maintenance Director will given an in-service on approantifreeze freezing points per Safety Code. The technician SafeCare was out on 5/25/2 the quarterly inspection. He confirmed the temps of 9 and degrees (report not yet avail for download). SafeCare reports.	06/23/2021 If be dents by by by the other all to dicient be a from 1 for d 11 able		

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	A. BUILDING B. WING	01	COMP	E SURVEY PLETED
		155733	_	ADDRESS, CITY, STATE, ZIP	_	1/2021
	PROVIDER OR SUPPLIER AL NURSING HOME			NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
				that they typically do solution until the free above 15 degrees. T preparing a quote to freezing point of the substitute to the end of the end	ezing point get they are lower the solution. ction(s) will ure the I not recur, urance nto place? he antifreeze monitored if the Any negative sted by the . The result of e discussed at nitor for any	
K 0363 SS=E Bldg. 01	than required enclopenings, exits, or the passage of sm inch solid-bonded material capable of 20 minutes. Doors compartments are passage of smoke to rooms containing combustible mater hardware. Roller la	hazardous areas resist oke and are made of 1 3/4 core wood or other f resisting fire for at least in fully sprinklered smoke only required to resist the . Corridor doors and doors				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	ETED
		155733	B. WIN	G		05/24/	2021
			' 	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t.		119 N IN	NDIANA AVE		
COLONIA	AL NURSING HOM	E	CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		spaces that do not contain					
	flammable or com						
		en bottom of door and floor					
	-	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
		device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	_	rs. Hold open devices that					
		door is pushed or pulled					
		nrated protective plates of					
	unlimited height are permitted. Dutch doors						
	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or						
	unless the smoke	compliance with 8.3,					
		fire window assemblies					
	are allowed per 8.						
		ere are no restrictions in					
		ince of glass or frames in					
	window assemblie	_					
	· ·	Parts 403, 418, 460, 482,					
	483, and 485						
		(S details of doors such as					
	· ·	ngs, automatics closing					
	devices, etc.	1			14000 0 11 -		0.5/0.0/5.5.5
		on and interview, the facility	K 03	63	K363 Corridor- Doors		06/23/2021
		f over 100 corridor doors			What corrective action(s) will b		
	-	a means suitable for keeping			accomplished for those resider		
		I no impediment to closing, resist the passage of smoke in			found to have been affected by	/	
	_	C 19.3.6.3. This deficient			the deficient practice?		
		t up to 10 residents, staff and			No residents were harmed by	the	
	visitors near Reside				alleged deficient practice. The		
	visitors near ixestue	nt Room 111.			door knob on room 111 was		
	Findings include:				swapped with a new door knob which properly latched each tir		
	During a facility sur	rvey with the Administrator			it was tested.		
		irector on 05/24/2021 at			How the facility will identify oth	er	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	01	COMPI	
		155733	B. W	ING		05/24	/2021
	PROVIDER OR SUPPLIER		<u> </u>	119 N II	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	11:10 a.m., the corr 111 failed to latch v Based on interview the Maintenance Di Resident Room 111	idor door to Resident Room when tested multiple times. at the time of observation, rector agreed that the door to failed to latch.			residents having the potential be affected by the same defice practice and what corrective action will be taken? A facility wide audit of corridor doors was completed by the Maintenance Director and any deficiencies were immediately corrected. What measures will be put interplace or what systematic changes the facility will make ensure the deficient practice does not recur? An inservice was done with the Director of Maintenance on the proper securing of corridor do and smoke/fire protection. How the corrective action(s) who be monitored to ensure the deficient practice will not recurred. A performance improvement the deficient practice will not recurred. What quality assurance program will be put into place. A performance improvement the was created that will audit 10 random corridor doors in the building each week for 3 monitiand then bi-weekly for an additional 3 months. Above autool to be reviewed in the QA meeting at least quarterly. By what date the systemic changes will be completed? 6/23/21	to ient o to to to e e ors vill r, ? oool	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie	lding Spaces - Smoke					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	01	COMPL	ETED
		155733	B. W	ING		05/24/	2021
				CTREET	ADDRESS SITY STATE ZID SODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
001.011	A. A.I. IDOINIO I IOM	.=			NDIANA AVE		
COLONIA	AL NURSING HOM	E		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	Subdivision of Bui	ilding Spaces - Smoke					
	Barrier Constructi	on					
	2012 EXISTING						
	Smoke barriers sh	nall be constructed to a					
	1/2-hour fire resis	tance rating per 8.5.					
	Smoke barriers sh	nall be permitted to					
	terminate at an at	rium wall. Smoke dampers					
	are not required ir	n duct penetrations in fully					
	ducted HVAC systems where an approved						
	sprinkler system is	s installed for smoke					
	compartments adj	jacent to the smoke barrier.					
	19.3.7.3, 8.6.7.1(1	1)					
	Describe any med	chanical smoke control					
	system in REMAF	RKS.					
	Based on observation	on and interview, the facility	K 0	372	K372 Subdivision of Build	ing	06/23/2021
	failed to ensure 2 or	f 2 smoke barrier walls in the			Spaces- Smoke Barrier		
	basement was main	tained in accordance with			Construction		
	LSC Section 19.3.7	7.5. Section 19.3.7.5 requires			What corrective action(s) will I	be	
	smoke barriers to be	e constructed in accordance			accomplished for those reside	nts	
	with LSC Section 8	3.5 and shall have a minimum			found to have been affected b	y	
	½ hour fire resistive	e rating. Section 8.5.2 states			the deficient practice?		
	that smoke barriers	shall be continuous from			No residents were harmed by	the	
		side wall and continuous			alleged deficient practice. The	,	
		ed spaces. This deficient			Maintenance Director sealed t		
	practice could affect	et staff only.			area that was identified with the	ne	
					appropriate fire caulk material		
	Findings include:				How the facility will identify oth		
					residents having the potential		
	During a tour of the				be affected by the same defici		
		tor on 05/24/2021 at 11:25			practice and what corrective	C/IL	
		ment smoke barrier was found			action will be taken?		
		nular gap around piping. Then,			A facility wide audit of smoke		
	· ·	outh Basement smoke barrier			barriers was completed by the	١	
		around communications			Maintenance Director and any		
		nterview at the time of each			deficiencies were immediately		
	observation, the Ma				corrected.		
	confirmed the non-	sealed penetrations.			What measures will be put into	_	
					· ·	,	
		ng was reviewed with the			place or what systematic	*	
	Administrator at the	e time of exit.			changes the facility will make	ιο	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155733	B. WING		05/24/2021
	ROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			ensure the deficient practice does not recur? An inservice was done with the Director of Maintenance on the proper appearance and sealing smoke barriers and smoke/firm protection. How the corrective action(s) was be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place. A performance improvement was created that will audit 2 smoke barriers in the building each week for 3 months and bi-weekly for an additional 3 months. Above audit tool to be reviewed in the QA meeting a least quarterly. By what date the systemic changes will be completed? 6/23/21	ng of e vill r, ? tool then
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to protect 1 of accordance with NF Electrical Code. Se Live Parts. (A) Live	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life. 9.1.1, 9.1.2 on and interview the facility f 1 electrical panel in	K 0511	K511 Utilities- Gas and Elect What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice?	be ents

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDI		NSTRUCTION 01	(X3) DATE COMPL	
THE TENNY	o. conduction	155733	B. WING		<u>U I </u>	05/24/	
		.557.00	l or	DEET A	ADDRESS, CITY, STATE, ZIP CODE	30,24,	
NAME OF P	ROVIDER OR SUPPLIER				NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	NG			DATE
		ed by this Code, live parts of toperating at 50 volts or			No residents were harmed by alleged deficient practice. The		
		ed against accidental contact			Maintenance Director installed		
	_	ures or by any of the			locking device onto the identif		
) By location in a room,			electrical panel prohibiting	ica	
		losure that is accessible only			access unless a key was		
	to qualified persons	. This deficient practice			available.		
	could affect staff an	d up to 10 residents.			How the facility will identify of	her	
					residents having the potential		
	Findings include:				be affected by the same defic		
	During a town of the	facility with the			practice and what corrective		
	During a tour of the	Maintenance Director on			action will be taken?		
		a.m. the electrical panel			A facility wide audit of electric	al	
		121 was not secured. Based			panels was completed by the		
		dministrator and Maintenance			Maintenance Director and any		
	·	residents had access to the			deficiencies were immediately	′	
	area and the unlock	ed panel would be a hazard.			corrected.		
					What measures will be put int	0	
		ng was reviewed with the			place or what systematic	4-	
	Administrator at the	e time of exit.			changes the facility will make ensure the deficient practice	10	
	2.1.10(1)				does not recur?		
	3.1-19(b)				An inservice was done with th	e	
					Director of Maintenance on th		
					proper sealing of electrical an		
					utility panels.		
					How the corrective action(s) v	vill	
					be monitored to ensure the		
					deficient practice will not recu	r,	
					i.e., what quality assurance		
					program will be put into place		
					A performance improvement to	ool	
					was created that will audit 3	•	
					random electrical panels in the building each week for 3 mon		
					and then bi-weekly for an	u 10	
					additional 3 months. Above at	udit	
					tool to be reviewed in the QA	***	
					meeting at least quarterly.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETE			ETED	
		155733	B. WING	B. WING 05/24/2021			/2021
			ST	DEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	₹					
COLONIA	AL NUIDOING LION	Г			NDIANA AVE		
COLONIA	AL NURSING HOM	E	Cr	ROWN	I POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
					By what date the systemic		
					changes will be completed?		
					6/23/21		
K 0712	NFPA 101						'
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include	the transmission of a fire					
		simulation of emergency					
		e drills are held at					
		expected times under					
	-	s, at least quarterly on each					
		amiliar with procedures					
		drills are part of established					
		rills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	ay be assa metsaa er					
	19.7.1.4 through	19717					
		view and interview, the	K 0712		K712 Fire Drills		06/23/2021
		nduct 5 of 12 quarterly shift	K 0/12		What corrective action(s) will be	20	00/23/2021
		e most recent 12 month time					
	_	1.6 requires drills to be			accomplished for those reside		
	1 ~	y on each shift under varied			found to have been affected b	У	
		the COVID-19 Public Health			the deficient practice?		
		ized training could be used in			No residents were harmed by	the	
	"	9			alleged deficient practice.		
		his deficient practice affects			How the facility will identify oth	ner	
	all staff and residen	its.			residents having the potential	to	
					be affected by the same defici	ent	
	Findings include:				practice and what corrective		
					action will be taken?		
	_	ew with the Maintenance			A review of the current year's	fire	
		2021 at 9:50 a.m., the facility			drills was conducted by the	0	
		ide documentation of a fire			Director of Maintenance to		
		d 3rd shift for the Second			ensure that all were conducted	d in	
	1	2021; the 1st, 2nd, 3rd shift					
		of 2020. Based on interview			the proper time frame. The find	aı	
		d review, the Maintenance			drill for the quarter will be		
		he began in October, 2020			completed prior to 6/23/21.		
	and could provide i	no documentation of fire drills			What measures will be put into	כ	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733		A. BUILDING 01 B. WING	COMPLETED 05/24/2021		
	PROVIDER OR SUPPLIER AL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON BE PRIATE COMPLETION DATE		
	or authorized training prior to that month. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) 3.1-51(c)	place or what systematic changes the facility will may ensure the deficient practic does not recur? The Director of Maintenance received an inservice on find procedure and timing. How the corrective action(s) be monitored to ensure the deficient practice will not receive a will not receive a will be put into play the Director of Maintenance/Designee will perform a monthly audit of drills to ensure that drills we conducted and the next moderies will be made up during current quarter to ensure compliance. The audit will reviewed at least quarterly QA meeting to ensure that drills are being conducted appropriate timeframe. By what date the systemic changes will be completed 6/23/21	ce ce drill c) will ccur, ce cece? dfire ere conth's cissed g the be in the all in the		
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	ETED
		155733	B. WIN	G		05/24/	2021
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
COLONIA	AL NURSING HUM	L		CROWN	N POINT, IN 46307		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	nths for 4 continuous					
	hours. Scheduled	test under load conditions					
	include a complete	e simulated cold start and					
	automatic or manu	ual transfer of all EES					
	loads, and are conducted by competent						
	personnel. Maintenance and testing of stored						
	energy power sources (Type 3 EES) are in						
	accordance with NFPA 111. Main and feeder						
		e inspected annually, and					
		odically exercising the					
		tablished according to					
		irements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
	-	arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r	<u> </u>					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		review and interview, the	K 09	₁₈	K918 Electrical Systems-		06/23/2021
		intain a complete written		-~	Essential Electrical System		30.20.2021
	-	generator load testing for 5 of			Maintenance and Testing		
		Chapter 6.4.4.1.1.4(a) of			What corrective action(s) will b	е	
		nires monthly testing of the			accomplished for those resider		
	_	e emergency electrical			found to have been affected by		
	-	ordance with NFPA 110, the			the deficient practice?	,	
	-	ency and Standby Powers			No residents were identified or		
	_	NFPA 110 8.4.2 requires			harmed by the alleged deficien		
		s in service to be exercised at			•		
	-	for a minimum of 30			practice. The generator receive		
		4.4.2 of NFPA 99 requires a			its weekly test on 5/31/21 and	IS	
					functioning properly.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
		155733	B. WING			05/24/2021	
				CTREET 4	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
001 01111 1111 01110 110115					NDIANA AVE		
COLONIA	AL NURSING HOM	E		CROWN POINT, IN 46307			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG DEFICIENC		DATE	
	written record of inspections, performance			How the facility will identify other		ner	
	parameters, exercising period, and repairs for the			residents having the po		to	
	generator to be regu	ılarly maintained and	ļ		be affected by the same deficient		
available for inspect		ction by the authority having			practice and what corrective		
_		eficient practice could affect			action will be taken?		
	all occupants.				A facility wide audit was done		
					which showed all generator te	stina	
	Findings include:				since October 2020 was up to		
					date. This included inspections		
	Based on record rev	view with the Maintenance			SafeCare, the generator servi	-	
	Director on 05/24/2	021 at 9:40 a.m.,			company. Safecare was also		
	documentation for testing for dates prior to				contacted to schedule a 4 hou	ır	
	October, 2020 were not available for review.				lode bearing test which will be	,	
	Based on an interview at the time of record				done prior to 6/23/21.		
	review, the Maintenance Director stated he began				What measures will be put into	o	
	in October, 2020 and could provide no				place or what systematic		
	documentation prior to that month.				changes the facility will make	to	
					ensure the deficient practice		
		ng was reviewed with the			does not recur?		
	Administrator at the time of exit.				The maintenance director		
					received an in-service on		
	3.1-19(b)				generator testing requirements	s.	
	(A) D 1 1				How the corrective action(s) w		
		review and interview, the			be monitored to ensure the		
	•	intain 1 of 1 Emergency			deficient practice will not recui	r.	
		tem in accordance with NFPA			i.e., what quality assurance	,	
	110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99				program will be put into place?	?	
					A performance improvement to		
	Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1				was created that will be done		
	Emergency Power Systems shall be tested at				weekly for 3 months and then		
	least once within every three years. Where the				bi-weekly for 3 months to ensu		
	assigned class is greater than 4 hours, it shall be				that all testing is completed in		
	permitted to terminate the test after 4 hours.				recommended timeframe. Abo		
	NFPA 99 Section 6.4.1.1.6.1 states that Type 1				audit tool to be reviewed in the	∍ QA	
	and Type 2 essential electrical system power sources shall be classified at Type 10, Class X,				meeting at least quarterly.		
					By what date the systemic		
		ets. This deficient practice			changes will be completed?		
	could affect all buil	-			6/23/21		
		C 1					
1	i		1				

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/24/2021			
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	Director on 05/24/2 provided document emergency generate documentation of a was confirmed by to	wwwith the Maintenance 1021 at 9:40 a.m., the facility 1021 at 10:40 a.m., the facility 1021 ation for testing of the 1021 provide 1021 at 102							

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