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	06/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/06/2022 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Emergency Preparedness survey, Colonial Nursing Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 34. Quality Review completed on 06/08/22	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance to the Life Safety survey conducted on June 6, 2022 and request paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/06/2022 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Life Safety Code survey, Colonial Nursing Home was found not in compliance with	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance to the Life Safety	

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in some of the corridors, some spaces open to the corridors and in some resident rooms. Battery operated smoke detectors are located in some of the corridors, some spaces open to the corridors and in some resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 34. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 06/08/22		survey conducted on June 6, 2022 and request paper compliance.	
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number			

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	of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on observation and interview, the facility was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition, Section 4.1, 4.1.1 and Table 4.1.1. This deficient practice could affect all 34 residents. Findings include: Based on observation with the Administrator and	K 0161	**K161 Building Construction Type and Height** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the*	09/05/2022

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	Maintenance Director on 06/06/2022 during a tour of the facility from 2:10 p.m. to 3:28 p.m., observation of the unprotected wood structure revealed that the type of construction of the building was Type V (000) and the building was two stories. Type V (000) is not an acceptable type of construction for a two-story existing healthcare building. This finding was confirmed by the Administrator and the Maintenance Director at the time of discovery. 3.1-19(b)		*basement levels and 2nd floor will require the installation of smoke and heat detectors. Once the smoke detection system is installed, it will give these zones a passing FSES score, including the stairwell. Installation has been delayed by plan review and SafeCare obtaining the necessary equipment to complete the smoke detection system.* *Based on FSES scoring, additional work will need to be done to upgrade the smoke detection system. Total Coverage smoke detection includes the installation of automatic smoke detection in all rooms, halls, storage areas, basements, attics, lofts, spaces above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevator shafts, enclosed stairways, dumb waiter shafts and chutes (NFPA 72-2010 Section 17.5.3.1).* *The facility hired the company, SafeCare, to designate areas requiring additional smoke detection coverage. They will also upgrade the Fire Alarm System. SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Security for the design release. Once the designs have been released, SafeCare will install/replace the*	

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			following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull stations and relay modules with a completion date of September 5th 2022. Once the install has been completed Life safety will be notified to give certification of completed engineer plans that were accepted by Plan review. *A new FSES will be conducted by RTM on June 29, 2022.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* *Potentially all residents could be affected by the alleged deficiency. Administrator will review the FSES documentation and request FSES review annually by an independent company.* *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *The Maintenance Director will be educated on the proper FSES paperwork for the Life Safety binder.* *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* *Proper FSES paperwork will be reviewed in QAPI meeting on at*	

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			least a quarterly basis. *By what date the systemic changes will be completed?* **9/5/2022**	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to provide and maintain exit stairs and exit stair enclosures in accordance with NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.3.2.1, 7.1.3.2.3, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1, 7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, 7.7.3, 7.7.3.4, 7.2.2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2 and Table 7.2.2.2.1.1 (b). This deficient practice could affect approximately 6 of the 34 residents. Based on observations with the Administrator and Maintenance Director on 06/06/2022 during a tour of the facility from 2:10 p.m. to 3:28 p.m., the following was discovered: a) the exit stair by room 201 was not enclosed in fire rated construction. The door to the stair did not have fire resistance rating. b) the stair by room 201 consisted of metal open grate walking surfaces. The landing and all of the stair treads were metal open grate where there was 1/4 inch piece of metal and a 1 inch gap between the 1/4 inch metal pieces. This building is a healthcare occupancy. c) the stair by room 201 continued down from the upper landing 24 risers to the bottom of the stair without an intermittent landing. The approximately 15 foot distance exceeded the	K 0225	**K225 Stairways and Smokeproof Enclosures** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *Requesting compliance with alleged deficiency through the Life Safety Equivalency granted through the FSES once all required work in the FSES is complete and a passing score is achieved. These stairs would only be used in an emergency situation, i.e. fire evacuation and do reach the sidewalk downstairs for egress to outside the building. An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor will require the installation of smoke and heat detectors. Once the smoke detection system is installed, it will give these zones a passing FSES score, including the stairwell. Installation has been delayed by plan review and*	09/05/2022

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	allowable maximum 12 foot distance between landing. d) the stair by room 201 only had a 30 inch clear width and not the required minimum 36 inch clear width. These findings were confirmed by the Administrator and the Maintenance Director at the times of discovery and exit conference. 3.1-19(b)		*SafeCare obtaining the necessary equipment to complete the smoke detection system.* *Based on FSES scoring, additional work will need to be done to upgrade the smoke detection system. Total Coverage smoke detection includes the installation of automatic smoke detection in all rooms, halls, storage areas, basements, attics, lofts, spaces above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevator shafts, enclosed stairways, dumb waiter shafts and chutes (NFPA 72-2010 Section 17.5.3.1).* *The facility hired the company, SafeCare, to designate areas requiring additional smoke detection coverage. They will also upgrade the Fire Alarm System. SafeCare has submitted the necessary paperwork to the Indiana State Department of Health and Homeland Security for the design release. Once the designs have been released, SafeCare will install/replace the following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull stations and relay modules with a completion date of September 5th 2022. Once the install has been completed Life safety will be*	

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			notified to give certification of completed engineer plans that were accepted by Plan review. *A new FSES survey will be conducted on 6/29/22 by RTM.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* *Potentially 6 residents on the upper floor could be affected. The above remedies cover all potential stairways and smokeproof enclosures.* *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *The Maintenance Director will be educated on the proper FSES paperwork for the Life Safety binder.* *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* *Proper FSES paperwork will be reviewed in QAPI meeting on at least a quarterly basis.* *By what date the systemic changes will be completed?* **9/5/22**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 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 at least 6 residents and staff in therapy. Findings include: Based on observation with the Administrator and Maintenance Director during a tour of the facility from 2:10 p.m. to 3:28 p.m. on 06/06/22, two holes of an approximate 3"-4" diamater each were discovered in the ceiling of a closet in therapy.	K 0353	**K353 Sprinkler System-maintenance and testing** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *The residents and staff in the identified area were not harmed by the alleged deficient practice. The 2 areas identified by the surveyor were patched by the Director of Maintenance using 5/8 drywall to give the area 1 hour protection and create a smooth continuous ceiling.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* No other residents were affected by the alleged deficient practice. A	06/20/2022

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	These holes penetrated through the drywall exposing the space above and could delay the activation of the sprinklers installed in the closet. The approximate dimensions were confirmed by the Maintenance Director. Based on interview at the time of observation, the Maintenance Supervisor stated he did not know there were holes in the ceiling and would repair the penetrations. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		facility wide audit of sprinkler heads and the ceiling surrounding them was completed by the Maintenance Director to ensure that there was a smooth, continuous ceiling. No other areas were found. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper ceiling space around a sprinkler head. An audit tool was created to monitor the ceiling surrounding sprinklers. *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?* The Director of Maintenance or Designee will conduct an audit of 5 random sprinkler heads in the building to ensure that the surrounding ceiling meets NFPA guidelines of a smooth continuous surface. The audit will be conducted weekly times 4 then monthly times five. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/20/22**	
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers			

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Bldg. 01	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers on the second floor was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect 6 residents and staff on the second floor. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director on 06/06/2022 at 2:15 p.m. an ABC portable fire extinguisher was sitting unsupported in a wall alcove on the second floor. The fire extinguishers was near resident room 201. Based on interview at the time of observation, the Administrator confirmed the extinguisher was sitting unmounted in an alcove and would have it properly installed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0355	**K355 Portable Fire Extinguishers** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *The residents and staff in the identified area were not harmed by the alleged deficient practice. The fire extinguisher in the wall recess was attached to the wall using a mounting bracket.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* No other residents were affected by the alleged deficient practice. A facility wide audit of fire extinguishers was completed by the Maintenance Director to ensure that all were properly stored according to NFPA guidelines. No unsecure fire extinguishers were found. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper securing of fire extinguishers according to NFPA	06/20/2022

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			guidelines. An audit tool will be created to ensure that the fire extinguishers are properly secured according to NFPA guidelines. *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?* The audit tool will be completed by the Director of Maintenance or designee weekly times four then monthly times five to ensure that 5 random fire extinguishers in the building are being properly stored. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/20/22**	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the	K 0522	**K522 HVAC- Any Heating Device** *What corrective action(s) will be*	06/20/2022

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COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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	outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observations during a tour of the facility with the Administrator and Maintenance Director on 06/06/2022 at 3:15 p.m., the laundry room had fuel fired dryers with an automatic louver system that would provide air from the outside. There was a piece of cardboard taped over the intake which prevented fresh air to come in from the outside. Based on interview at the time of observation, the Maintenance Director agreed the cardboard was covering the entire fresh air intake in the dryer room. The Administrator removed the cardboard that was taped over the intake, which provided the room with air from the outside. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		*accomplished for those residents found to have been affected by the deficient practice?* *No residents were identified as being harmed by the alleged deficient practice. The piece of cardboard was immediately removed while the surveyor was present allowing fresh air intake into the dryer room from outside.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* No other residents were affected by the alleged deficient practice. This is the only laundry area in the facility. No other areas in the building required checking. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance and laundry staff on the proper ventilation and dangers of blocking air intakes. An audit tool was created to ensure that this area is monitored and not obstructed preventing fresh air intake. *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?* The audit tool will be completed by the Director of Maintenance or designee weekly times four then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 01 B. WING	06/06/2022

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			monthly times five to ensure that the air intake in the laundry area is not obstructed allowing for proper air intake. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/20/22**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 2 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 19.7.1.4 requires fire 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. Findings include: Based on record review of titled "Fire Drill Report"	K 0712	**K712 Fire Drills** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *All residents could potentially be harmed by the alleged deficient practice. A fire drill will be conducted during the day shift on 6/24/22. All proper steps will be followed and the monitoring company will notified of the drill.* *How the facility will identify other residents having the potential to be affected by the same deficient*	06/24/2022

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	with the Maintenance Director on 06/06/2022 at 12:10 p.m., two fire drills lacked documentation to indicate transmission of signal. The fire drills dated 03/30/2022 at 3:30 p.m. and 03/31/2022 at 5:30 a.m. had 'N/A' typed in the transmission of signal area on the forms. Based on interview at the time of record review, the Maintenance Director confirmed that the transmission of alarm did not occur on the aforementioned fire drills. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		*practice and what corrective action will be taken?* All residents could potentially be affected by the alleged deficient practice. An audit of the drill conducted on 6/24/22 will done to ensure that proper protocol was followed and the monitoring company was notified. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* An in-service was done with the Director of Maintenance on the proper fire drill and notification procedures. An audit tool was created to ensure that all fire drills are conducted properly. *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?* The audit tool will be completed by the Director of Maintenance or designee monthly times six to ensure that all fire drills that month were properly conducted, and the monitoring company was notified. If there are any errors identified another drill will be conducted to ensure proper procedures are followed. This information will be reviewed in the QA meeting at least quarterly. *By what date the systemic changes will be completed?* **6/24/22**	

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