DEPARTMENT	OF HEALTH AND HUM	IAN SERVICES
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COMPLE		ETED	
		155733	B. WING 06/06/20			2022	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
COLONIA	VI NILIDOINIO LIOMI	=			NDIANA AVE N POINT, IN 46307		
COLONIA	AL NURSING HOMI	=		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Ŭ	An Emergency Prep	paredness Survey was	E 00	000	By submitting the enclosed		
		diana Department of Health in		, , ,	material we are not admitting t	he	
	accordance with 42	-			truth or accuracy of any specif		
					findings or allegations. We	.0	
	Survey Date: 06/06	0/2022			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	.555	
	AIM Number: 1002				regulatory obligations. Colonia	al	
	711171 1 (41110-61) 1 0 0 2	2,03,10			Nursing and Rehab requests		
	At this Emergency I	Preparedness survey, Colonial			the plan of correction be	liiat	
		found in compliance with			considered our allegation of		
	-	dness Requirements for			compliance to the Life Safety		
		caid Participating Providers			survey conducted on June 6, 2	ກດວວ	
	and Suppliers, 42 C				and request paper compliance.		
	and Suppliers, 42 C.	1 K 403.73			and request paper compliance	•	
	The facility has 55 o	certified beds. At the time of					
	the survey, the cens						
	the survey, the cens	us was 54.					
	Quality Review con	anleted on 06/08/22					
	Quanty Review con	ipicted on 00/00/22					
K 0000							l
1.0000							
Bldg. 01							
Blag. 01	Δ Life Safety Code	Recertification and State	K 0	000	By submitting the enclosed		ı
		ere conducted by the Indiana	I K U	000	material we are not admitting t	ho	
	_	th in accordance with 42 CFR			truth or accuracy of any specif		
	_	th in accordance with 42 CFR				iC	
	483.90(a).				findings or allegations. We		
	Survey Date: 06/06	//2022			reserve the right to contest the		
	Survey Date. 00/00	1/2022			findings or allegations as part		
	Facility Number: 0	00360			any proceedings and submit the	ICSC	
	Provider Number: 1				responses pursuant to our	-I	
					regulatory obligations. Colonia		
	AIM Number: 1002	2903 / 0			Nursing and Rehab requests	ınat	
	AAALI-TIC CIC.	Cala			the plan of correction be		
	-	Code survey, Colonial Nursing			considered our allegation of		
	nome was found no	t in compliance with			compliance to the Life Safety		
					l		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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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PRINTED: 09/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 6/2022	
	PROVIDER OR SUPPLIEF		119 N	ADDRESS, CITY, STATE, ZIP CO INDIANA AVE /N POINT, IN 46307	OD -	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupa- Colonial Nursing H with a basement of was built at three di building was constructed in 1986 fully sprinklered an detection located in spaces open to the c rooms. Battery ope located in some of to open to the corridor The facility has 55 dually certified for the time of the surv All areas where the access and areas pre sprinklered.	articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  ome is a two-story building Type V (000) construction that fferent times. The original ucted in 1906 with additions and 1994. The building is d there is supervised smoke some of the corridors, some corridors and in some resident rated smoke detectors are the corridors, some spaces and in some resident rooms.  certified beds. All 55 beds are Medicare and Medicaid. At ey, the census was 34.  residents have customary oviding facility services were		survey conducted on Ju and request paper com		
K 0161 SS=F Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, ur 19.1.6.2 through 19.1.6.4, 19.1.6.5	tion Type and Height tion Type and Height ion type and stories meets less otherwise permitted by 9.1.6.7 tion Type (332), II (222) Any number				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/06/2022	
	NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	sprinklered	non-sprinklered and			
	2 II (111) non-sprinklered	One story  Maximum 3 stories			
	sprinklered 3 II (000)	Not allowed			
	non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)				
	throughout by an automatic system 9.7. (See 19.3.5)	Not allowed  Maximum 1 story  s must be sprinklered approved, supervised in accordance with section  iption, in REMARKS, of the			
	basements, floors located, location of dates of approval	number of stories, including on which patients are of smoke or fire barriers and . Complete sketch or attach the building as appropriate.			
	was not an acceptal required by NFPA 19.1.6.1, 4.5.8 and Section 4.1, 4.1.1 a practice could affect	on and interview, the facility ble type of construction as 101 - 2012 edition, Sections NFPA 220 - 2012 edition, nd Table 4.1.1. This deficient et all 34 residents.	K 0161	K161 Building Construction Type and Height What corrective action(s) will accomplished for those reside found to have been affected be the deficient practice? An independent company, R7	ents Py TM,
	Findings include:  Based on observation	on with the Administrator and		completed an FSES review in 2021 and determined all the Interstitial spaces of the	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			ETED	
		155733	B. W	ING		06/06/	2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t			NDIANA AVE		
COLONIA	AL NURSING HOM	F			N POINT, IN 46307		
COLOIVI	1101101110111						
(X4) ID		STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		for on 06/06/2022 during a tour			basement levels and 2nd floor		
		2:10 p.m. to 3:28 p.m.,			require the installation of smol	ke	
		inprotected wood structure			and heat detectors. Once the		
		pe of construction of the			smoke detection system is		
		V (000) and the building was			installed, it will give these zone		
		(000) is not an acceptable			passing FSES score, including		
	healthcare building	n for a two-story existing			the stairwell. Installation has b	een	
	nearmeare building.	•			delayed by plan review and	0011	
	This finding was as	onfirmed by the Administrator			SafeCare obtaining the neces	-	
		e Director at the time of			equipment to complete the sm detection system.	IUKE	
	discovery.	e Director at the time of			Based on FSES scoring,		
	discovery.				additional work will need to be	,	
	3.1-19(b)				done to upgrade the smoke	•	
	3.1 17(0)				detection system. Total Cover	ane	
					smoke detection includes the	ugo	
					installation of automatic		
					smoke detection in all rooms,		
					halls, storage areas, basemen	nts.	
					attics, lofts, spaces above	,	
					suspended ceilings, and other		
					subdivisions and accessible		
					spaces as well as the inside o	f all	
					closets, elevator shafts, enclo		
					stairways, dumb waiter shafts	and	
					chutes (NFPA 72-2010 Sectio	n	
					17.5.3.1).		
					The facility hired the company	<b>'</b> ,	
					SafeCare, to designate areas		
					requiring additional smoke		
					detection coverage. They will		
					upgrade the Fire Alarm Syster	n.	
					SafeCare will submit the		
					necessary paperwork to the		
					Indiana State Department of	_	
					Health and Homeland Security	y for	
					the design release. Once the		
					designs have been released,		
			1		SafeCare will install/replace th	ne	

PRINTED: 09/20/2022

	Γ OF HEALTH AND HU R MEDICARE & MEDIO					RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPLI 06/06/2	SURVEY ETED
	PROVIDER OR SUPPLIE		119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE 'N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
				following items: a new fire para additional smoke and heat detectors, carbon monoxide detectors, strobes, pull station and relay modules with a completion date of Septembe. 2022. Once the install has be completed Life safety will be notified to give certification of completed engineer plans that were accepted by Plan review. A new FSES will be conducte RTM on June 29, 2022. How the facility will identify other in the facility will identify other in the facility all residents could affected by the same deficited and what corrective a will be taken? Potentially all residents could affected by the alleged deficited Administrator will review the F documentation and request F review annually by an independent of the facility will make to ensure deficient practice does not recompany. What measures will be put into place or what systematic chair the facility will make to ensure deficient practice does not recompany. The Maintenance Director will educated on the proper FSES	ns r 5th een  t v. d by her to cient action be ency. ESES ndent to nges e the cur? I be	

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Event ID:

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Facility ID: 000360

put into place?

binder.

paperwork for the Life Safety

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be

Proper FSES paperwork will be reviewed in QAPI meeting on at

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 06/06/2022	
	PROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0225	NFPA 101			least a quarterly basis. By what date the systemic changes will be completed? 9/5/2022	
SS=E Bldg. 01	Stairways and Sr Stairways and Sr as exits are in ac 18.2.2.3, 18.2.2.4 Based on observati	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2. 1., 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility	K 0225	K225 Stairways and	09/05/2022
	stair enclosures in 2012 edition, Secti 7.1.3.2.1, 7.1.3.2.3 7.2.2.1.1, 7.2.2.3.3 7.2.2.2.1, 7.2.2.2.1 7.7.3, 7.7.3.4, 7.2.2 and Table 7.2.2.2.1	ad maintain exit stairs and exit accordance with NFPA 101 - ons 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 1.7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, 2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2.1 (b). This deficient practice timately 6 of the 34 residents.		Smokeproof Enclosures What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? Requesting compliance with alleged deficiency through the Safety Equivalency granted through the FSES once all required work in the FSES is complete and a passing score	nts / Life
	and Maintenance I tour of the facility following was disc a) the exit stair by fire rated construct not have fire resists b) the stair by roon grate walking surfastair treads were m 1/4 inch piece of m the 1/4 inch metal; healthcare occupan	room 201 was not enclosed in ion. The door to the stair did ance rating.  n 201 consisted of metal open aces. The landing and all of the etal open grate where there was netal and a 1 inch gap between pieces. This building is a		achieved. These stairs would of be used in an emergency situation, i.e. fire evacuation and or each the sidewalk downstator egress to outside the building An independent company, RTI completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor require the installation of smok and heat detectors. Once the smoke detection system is installed, it will give these zone.	only  nd nirs ng. M, will
	1 '	sers to the bottom of the stair		passing FSES score, including the stairwell. Installation has be	,

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approximately 15 foot distance exceeded the

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delayed by plan review and

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DEPARTMENT OF HEALTH AND HU	FORM APPR		
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>	COMPLETED
	155733	B. WING	06/06/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD

NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			119 N INDIANA AVE CROWN POINT, IN 46307			
IAG	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)	IAG	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	DATE		

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DQE221 Facility ID: 000360

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/06/2022	
	PROVIDER OR SUPPLIER		119 N	ET ADDRESS, CITY, STATE, ZIP COD N INDIANA AVE WN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG	` `	LSC IDENTIFYING INFORMATION	TAG	notified to give certification of completed engineer plans the were accepted by Plan reviewall be conducted on 6/29/22 by RT.  How the facility will identify of residents having the potential be affected by the same defining practice and what corrective will be taken?  Potentially 6 residents on the upper floor could be affected above remedies cover all postairways and smokeproof enclosures.  What measures will be put in place or what systematic charter facility will make to ensure deficient practice does not resident practice does not resident.  How the corrective action(s) monitored to ensure the defining practice will not recur, i.e., we quality assurance program we put into place?  Proper FSES paperwork will reviewed in QAPI meeting of least a quarterly basis.	of at www.  TM.  TM.  other al to cicient action  et action  et action  into anges re the ecur?  iill be is so will be cicient that will be cicient that will be it be in the content of t
				By what date the systemic changes will be completed? 9/5/22	
K 0353 SS=E	NFPA 101 Sprinkler System	- Maintenance and Testing			
Bldg. 01		- Maintenance and Testing			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155733	B. WI	NG _		06/06	/2022
			1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			NDIANA AVE		
COLONIA	AL NURSING HOM	F			N POINT, IN 46307		
	T		_		1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	-	er and standpipe systems					
		ted, and maintained in					
		NFPA 25, Standard for the					
	-	g, and Maintaining of					
		Protection Systems. n design, maintenance,					
	-	sting are maintained in a					
		nd readily available.					
		system last checked					
	a, bate opinition	ayotom laot onconca					
	b) Who provided	system test					
	, , , ,	•					
	c) Water system	supply source					
	Provide in REMAR	RKS information on					
	coverage for any i	non-required or partial					
	automatic sprinkle	<u> </u>					
	9.7.5, 9.7.7, 9.7.8,						
		on and interview, the facility	K 0.	353	K353 Sprinkler System-		06/20/2022
		ne ceiling construction			maintenance and testing		
		lity. NFPA 13, 2010 edition,			What corrective action(s) will l		
		nes a smooth ceiling as a			accomplished for those reside		
		free from significant			found to have been affected b	y	
		s, or indentations. The ceiling			the deficient practice?		
		ses around the sprinkler and			The residents and staff in the	a al la . :	
	_	to operate at a specified n 8.5.4.1.1 states the distance			identified area were not harme	-	
	_	er deflector and the ceiling			the alleged deficient practice.		
	-	er deflector and the centing eted based on the type of			2 areas identified by the surve were patched by the Director	-	
		pe of construction. This			Maintenance using 5/8 drywai		
		ould affect at least 6 residents			give the area 1 hour protection		
	and staff in therapy				create a smooth continuous	, and	
					ceiling.		
	Findings include:				How the facility will identify oth	her	
					residents having the potential		
	Based on observation	on with the Administrator and			be affected by the same defici		
	Maintenance Direct	tor during a tour of the facility			practice and what corrective a		
		:28 p.m. on 06/06/22, two holes			will be taken?		
	_	3"-4" diamater each were			No other residents were affect	ted	
	discovered in the ce	eiling of a closet in therapy.			by the alleged deficient praction	ce. A	

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Event ID:

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COM		COMPL	ETED
		155733	B. W	ING		06/06/	/2022
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
001.011	AL NUIDOINO LION	E			NDIANA AVE		
COLONIA	AL NURSING HOM	E		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
	These holes penetra	ated through the drywall			facility wide audit of sprinkler		
	exposing the space	above and could delay the			heads and the ceiling surround	ding	
		rinklers installed in the closet.			them was completed by the	J	
	_	imensions were confirmed by			Maintenance Director to ensur	·e	
		irector. Based on interview at			that there was a smooth,		
	the time of observa	tion, the Maintenance			continuous ceiling. No other a	reas	
		e did not know there were			were found.		
	_	and would repair the			What measures will be put into	)	
	penetrations.	•			place or what systematic char		
	1				the facility will make to ensure	_	
	This finding was re	viewed with the Administrator			deficient practice does not rec		
		Director at the exit conference.			An in-service was done with the		
					Director of Maintenance on the		
	3.1-19(b)				proper ceiling space around a		
					sprinkler head. An audit tool w	as .	
					created to monitor the ceiling		
					surrounding sprinklers.		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici		
					practice will not recur, i.e., who		
					quality assurance program wil		
					put into place?		
					The Director of Maintenance of	r	
					Designee will conduct an audi		
					5 random sprinkler heads in the		
					building to ensure that the		
					surrounding ceiling meets NFI	PA	
					guidelines of a smooth continu		
					surface. The audit will be		
					conducted weekly times 4 the	n	
					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		
					J. 20,22		
K 0355	NFPA 101						

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Portable Fire Extinguishers

SS=E

Event ID:

DQE221

Facility ID: 000360

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	MPLETED	
1557		155733	B. WING		06/06	06/06/2022	
			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER					NDIANA AVE		
COLONIAL NURSING HOME					N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
Bldg. 01	Portable Fire Extir	•					
		guishers are selected,					
		d, and maintained in					
		NFPA 10, Standard for					
	Portable Fire Extir	•					
	18.3.5.12, 19.3.5.						0.5/20/2020
		on and interview, the facility	K 0	355	K355 Portable Fire		06/20/2022
		of 2 portable fire extinguishers			Extinguishers		
		was installed in accordance			What corrective action(s) will be		
	· ·	ndard for Portable Fire			accomplished for those reside		
	-	Edition. Section 6.1.3.4 states			found to have been affected by	У	
		uishers other than wheeled be installed using any of the			the deficient practice?		
	_	) Securely on a hanger			The residents and staff in the	ad by	
		inguishers. (2) In the bracket			identified area were not harme	-	
		nguisher manufacture. (3) In a			the alleged deficient practice.		
		wed for such purpose. (3) In a			fire extinguisher in the wall red		
		ss. This deficient practice			was attached to the wall using	ı a	
		ents and staff on the second			mounting bracket.  How the facility will identify oth	hor	
	floor.	ents and starr on the second			residents having the potential		
	11001.				be affected by the same defici		
	Findings include:				practice and what corrective a		
	i manigs metade.				will be taken?	Clion	
	Based on observation	on during a tour of the facility			No other residents were affect	ted	
		ator and Maintenance Director			by the alleged deficient practic		
		15 p.m. an ABC portable fire			facility wide audit of fire		
		tting unsupported in a wall			extinguishers was completed	by	
	_	d floor. The fire extinguishers			the Maintenance Director to		
		oom 201. Based on interview at			ensure that all were properly		
	the time of observat	tion, the Administrator			stored according to NFPA		
		guisher was sitting unmounted			guidelines. No unsecure fire		
		ould have it properly installed.			extinguishers were found.		
					What measures will be put into	0	
	This finding was re-	viewed with the Administrator			place or what systematic char	nges	
	and Maintenance D	irector at the exit conference.			the facility will make to ensure	the	
					deficient practice does not rec	ur?	
	3.1-19(b)				An in-service was done with the	ne	
					Director of Maintenance on the	е	
					proper securing of fire		
			1		extinguishers according to NF	PA	

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
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>			LETED
155733			B. W	ING		06/06	/2022
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENC BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE
					guidelines. An audit tool will I created to ensure that the fire extinguishers are properly se according to NFPA guideline How the corrective action(s) monitored to ensure the defic practice will not recur, i.e., wi quality assurance program with put into place?  The audit tool will be completed birector of Maintenance of designee weekly times four the monthly times five to ensure random fire extinguishers in the building are being properly story the QA meeting at least quark by what date the systemic changes will be completed?  6/20/22	e ecured s. will be cient that will be ted by or then that 5 the tored. wed in	
K 0522 SS=D Bldg. 01	heating plant, is discombustible mater device, and has a and shut down equivers excessive temper fuel fired, the deviter is chimney or vertakes air for come provides for a confrom occupied are 19.5.2.2	cing Device ce, other than a central designed and installed so crials cannot be ignited by a safety feature to stop fuel quipment if there is cature or ignition failure. If dice also: cent connected. combustion from outside. combustion system separate	K 0	522	K522 HVAC- Any Heating		06/20/2022

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failed to ensure 1 of 1 laundry rooms was

provided with intake combustion air from the

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**Device** 

If continuation sheet

What corrective action(s) will be

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/06/2022 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE outside for rooms containing fuel fired equipment. accomplished for those residents This deficient practice could create an atmosphere found to have been affected by rich with carbon monoxide which could cause the deficient practice? physical problems for all staff in the laundry room. No residents were identified as being harmed by the alleged Findings include: deficient practice. The piece of cardboard was immediately Based on observations during a tour of the facility removed while the surveyor was with the Administrator and Maintenance Director present allowing fresh air intake on 06/06/2022 at 3:15 p.m., the laundry room had into the dryer room from outside. fuel fired dryers with an automatic louver system How the facility will identify other that would provide air from the outside. There was residents having the potential to a piece of cardboard taped over the intake which be affected by the same deficient prevented fresh air to come in from the outside. practice and what corrective action Based on interview at the time of observation, the will be taken? Maintenance Director agreed the cardboard was No other residents were affected covering the entire fresh air intake in the dryer by the alleged deficient practice. room. The Administrator removed the cardboard This is the only laundry area in the that was taped over the intake, which provided facility. No other areas in the the room with air from the outside. building required checking. What measures will be put into This finding was reviewed with the Administrator place or what systematic changes and Maintenance Director at the exit conference. the facility will make to ensure the deficient practice does not recur? 3.1-19(b) 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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FO	R MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-0		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/06/2022		
	PROVIDER OR SUPPLIEI		1	TREET ADDRESS, CITY, STATE, ZI 19 N INDIANA AVE CROWN POINT, IN 46307	IP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF GEACH CORRECTIVE ACTIC CROSS-REFERENCED TO	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
				monthly times five to the air intake in the not obstructed allow air intake. This infor reviewed in the QA least quarterly. By what date the sy changes will be com 6/20/22	laundry area is ving for proper mation will be meeting at	
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.		K 0712	2 K712 Fire Drills What corrective acti accomplished for the found to have been the deficient practice All residents could p harmed by the alleg practice. A fire drill v conducted during th 6/24/22. All proper s followed and the mo- company will notifie	affected by ee? cotentially be ged deficient will be ne day shift on steps will be conitoring	06/24/2022

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Findings include:

Based on record review of titled "Fire Drill Report"

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If continuation sheet

How the facility will identify other residents having the potential to

be affected by the same deficient

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DEPARTMEN CENTERS FOI		FORM APPROVED OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/06/2022	
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE VN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF with the Maintenan 12:10 p.m., two fire indicate transmissic dated 03/30/2022 at 5:30 a.m. had 'N/A' signal area on the fotime of record revie confirmed that the toccur on the aforem.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION TO Director on 06/06/2022 at the drills lacked documentation to the on of signal. The fire drills that typed in the transmission of the orms. Based on interview at the text, the Maintenance Director transmission of alarm did not the nentioned fire drills.  Wiewed with the Administrator director at the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD INCOSS-REFERENCED TO THE APPROPODEFICIENCY)  practice and what corrective will be taken?  All residents could potential affected by the alleged defice practice. An audit of the drill conducted on 6/24/22 will densure that proper protocol followed and the monitoring company was notified.  What measures will be put if place or what systematic characteristic does not in the facility will make to ensure deficient practice does not in the facility will make to ensure deficient practice was done with Director of Maintenance on proper fire drill and notificating procedures. An audit tool was created to ensure that all fire are conducted properly.  How the corrective action(s, monitored to ensure the deficient practice will not recur, i.e., if you quality assurance program is put into place?  The audit tool will be completed being that were properly conducted, at monitoring company was not if there are any errors identification another drill will be conducted ensure proper procedures a followed. This information were viewed in the QA meeting least quarterly.	e action  ly be cient lone to was  into anges ure the recur? n the the on as e drills  i will be ricient what will be eted by or to month and the otified. If ied ed to are will be	(X5) COMPLETION DATE

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Event ID:

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6/24/22

If continuation sheet

By what date the systemic changes will be completed?

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/06/2022		
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	PREFIX (EACH CORRECTIVE ACTION SHOULD)		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	DEFICIENCY)	

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