PRINTED:	10/13/2022
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CC A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 09/07/2022
	PROVIDER OR SUPPLIE		119 N II	address, city, state, zip cod NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
0000					
Bldg. 01	Safety Code Recen Survey conducted	visit was conducted on the Life rtification and State Licensure by the Indiana Department of 2 in accordance with 42 CFR	K 0000		
	Survey Date: 09/0	07/2022			
	Facility Number: Provider Number: AIM Number: 10	155733			
	Home was found r Requirements for Medicare/Medicai Life Safety from F National Fire Prote Life Safety Code (v Code survey, Colonial Nursing not in compliance with Participation in d, 42 CFR Subpart 483.90(a), Fire and the 2012 edition of the ection Association (NFPA) 101, (LSC), Chapter 19, Existing pancies and 410 IAC 16.2.			
	with a basement of was built at three of building was const constructed in 198 fully sprinklered a detection located i spaces open to the rooms. Battery op located in some of open to the corrido	Home is a two-story building f Type V (000) construction that different times. The original tructed in 1906 with additions 66 and 1994. The building is nd there is supervised smoke n some of the corridors, some corridors and in some resident perated smoke detectors are the corridors, some spaces ors and in some resident rooms.			
	dually certified for	5 certified beds. All 55 beds are r Medicare and Medicaid. At vey, the census was 35.			

Any defiencystatement 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.

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION		OMB NO. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>01</u>	COMPLETED 09/07/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CC NDIANA AVE	D	
COLON	AL NURSING HOM	IE		N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION e residents have customary	TAG	DEFICILITY		DATE
		oviding facility services were				
	Quality Review co	mpleted on 09/13/22				
(0161	NFPA 101					
SS=F	Building Construct	ction Type and Height				
Bldg. 01	Building Construe 2012 EXISTING	tion Type and Height				
		tion type and stories meets				
19		nless otherwise permitted by				
	19.1.6.2 through					
	19.1.6.4, 19.1.6.5	•				
	1 I (442), of stories	ction Type (332), II (222) Any number non-sprinklered and				
	sprinklered					
	2 II (111) non-sprinklered	One story				
	non-spinikiered	Maximum 3 stories				
	sprinklered					
	3 II (000) non-sprinklered	Not allowed				
	4 III (211)	Maximum 2 stories				
	sprinklered 5 IV (2HH)				
	6 V (111)	,				
	7 III (200) non-sprinklered	Not allowed				
	8 V (000) sprinklered	Maximum 1 story				
		es must be sprinklered				
		approved, supervised				
	automatic system	in accordance with section	1	1		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DQE222 Facility ID: 000360

If continuation sheet

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PRINTED: 10/13/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 09/07/2022		
	PROVIDER OR SUPPLI IAL NURSING HOI			119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	construction, the basements, floor located, location dates of approva small floor plan of Based on intervier was not an accept required by NFPA 19.1.6.1, 4.5.8 and Section 4.1, 4.1.1 practice could affe Findings include: Based on record r Administrator and 09/07/22 from 9:1 was determined to evident by the unp the building was t an acceptable type existing healthcar review of the facil facility planned to prior to 09/05/22 is score on the FSES on an interview w the time of record completed the fire This finding was t Administrator at t This deficiency w	cription, in REMARKS, of the enumber of stories, including rs on which patients are of smoke or fire barriers and al. Complete sketch or attach of the building as appropriate. w and record review, the facility able type of construction as $(101 - 2012 \ edition, Sections)$ $(101 - 2012 \ edition, Section)$ $(101 - 2012 \ edition)$ $(101 - 2012 \ $	КО	161	K225 Stairways and Smokeproof Enclosures What corrective action(s) will be accomplished for those residen 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 achieved. These stairs would de be used in an emergency situation, i.e. fire evacuation and do reach the sidewalk downsta for egress to outside the buildi 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 passing FSES score, including the stairwell. Installation has b delayed by plan review and SafeCare obtaining the necess equipment to complete the sm detection system. Based on FSES scoring,	nts y Life is only nd airs ng. M, will ke es a g een sary	02/15/202

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3	3) DATE SURV	EY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		01	-	COMPLETED 09/07/2022	
		100100	D . 11			_	00/01/2022	-
NAME OF PI	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C INDIANA AVE	COD		
COLONIA	L NURSING HOM	ΛE			N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COM	MPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG				DATE
					additional work will nee			
					done to upgrade the si detection system. Tota		•	
					smoke detection includ	-	6	
					installation of automati			
					smoke detection in all			
					halls, storage areas, b			
					attics, lofts, spaces ab			
					suspended ceilings, ar	nd other		
					subdivisions and acces			
					spaces as well as the			
					closets, elevator shafts	-		
					stairways, dumb waite chutes (NFPA 72-2010			
					17.5.3.1).	Jection		
					The facility hired the co			
					SafeCare, to designate			
					requiring additional sm			
					detection coverage. The upgrade the Fire Alarn	-	0	
					SafeCare will submit th	-		
					necessary paperwork			
					Indiana State Departm			
					Health and Homeland	Security fo	or	
					the design release. Th			
					changes to NFPA 99 c			
					facility's essential elect			
					system. Based on info			
					from the engineer, plan not be necessary per A			
					at Indiana State Depar		, ,	
					Health (emails attache			
					SafeCare will install/re			
					following items: a new			
					additional smoke and l	heat		
					detectors, carbon mon			
					detectors, strobes, pul			
					and relay modules with			
	completion date of Decemb		cemper 5,					

	I OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/07/2022	
	ROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO	
				2022. Once the install has completed Life safety will be notified to give certification completed engineer plans. A new FSES survey was conducted on 6/29/22 by R completed paperwork includ SafeCare has attempted to the necessary parts to comp the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare see if the needed parts can obtained from a different ve We have also contacted Ko Fire Co. to see if they would able to complete the project sooner, which they could no (response included). No del start date can be given at the time. They estimated time to complete the project is 3-4 of The project is estimated to in October of 2022 pending availability of parts. The fac- committed to the installation the Complete Smoke Detect System described above to performed by SafeCare. The give the building a passing a in the FSES. Milestones Colonial nursing representative/designee will	been been of TM, ded. order olete e to be ndor. orsen d be finite his o weeks. start the ility is n of tion be is will score	
				communicate with vendor S Care at minimum 2 times per month for updates and	afe	

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		_	pleted 7/2022
NAME OF PI	ROVIDER OR SUPPLIE	ER		EET ADDRESS, CITY, STATE, ZIP C	COD	
COLONIA	L NURSING HOM	ИЕ) N INDIANA AVE OWN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIC
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG			DATE
				developments r/t pend Colonial Nursing	ing project.	
				representative/designe	e will report	
				update of status to ISE	-	
				pending project month		
				15th of each month an		
				new development unti		
				complete. Reporting w		
				writing by email and re	eference	
				Survey ID. ISDH will be notified in	writing by	
				email when parts are r	•••	
				Vendor to complete pr	•	
				Notified when project I	-	
				when project is comple	ete.	
				How the facility will id	-	
				residents having the p		
				be affected by the san		
				practice and what corr will be taken?	ective action	
				Potentially 6 residents	on the	
				upper floor could be a		
				above remedies cover		
				stairways and smokep	proof	
				enclosures.		
				What measures will be	-	
				place or what systema	-	
				the facility will make to deficient practice does		
				The Maintenance Dire		
				educated on the prope		
				paperwork for the Life	Safety	
				binder.		
				How the corrective act		
				monitored to ensure th		
				practice will not recur,		
				quality assurance prog put into place?	gram will be	
		Proper FSES paperwo	ork will be			
				reviewed in QAPI mee		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION (X	(3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155733	B. WING		09/07/2022
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD NDIANA AVE	
COLON	AL NURSING HOM	IE	-	N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				least a quarterly basis.	
				By what date the systemic	
				changes will be completed? 2/15/23	
0225	NFPA 101				
SS=E		nokeproof Enclosures			
Bldg. 01		nokeproof Enclosures			
	Stairways and Sr	nokeproof enclosures used			
		cordance with 7.2.			
		, 19.2.2.3, 19.2.2.4, 7.2			
failed to provide stair enclosures i 2012 edition, Sec		on and interview, the facility	K 0225	K225 Stairways and	02/15/2023
	-	nd maintain exit stairs and exit		Smokeproof Enclosures	
				What corrective action(s) will I	be
		ons 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.10, 7.1.10, 7.2.2, 7.2.2.1,		accomplished for those residents found to have been	
		, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2,		affected by the deficient	
		.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2,		practice?	
		2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2		p	
	and Table 7.2.2.1	.1 (b). This deficient practice		Requesting compliance with	
	could affect approx	ximately 6 of the 35 residents.		alleged deficiency through the	<u>a</u>
				Life Safety Equivalency grante	ed 🛛
	Findings include:			through the FSES once all	
				required work in the FSES is	
		ons with the Interim		complete and a passing score	is
		Maintenance Director on our of the facility from 9:30 a.m.		achieved. These stairs would	,
	-	following was discovered:		only be used in an emergency situation, i.e. fire evacuation	
		room 201 was not enclosed in		and do reach the sidewalk	
		ion. The door to the stair did		downstairs for egress to outsi	de
	not have fire resist			the building.	
		n 201 consisted of metal open			
	· ·	ices. The landing and all of the		An independent company,	
		etal open grate where there was		RTM, completed an FSES	
	-	netal and a 1-inch gap between		review in 2021 and determined	1
		pieces. This building is a		all the Interstitial spaces of the	
	healthcare occupar	-		basement levels and 2nd floor	
		1 201 continued down from the		will require the installation of	
		sers to the bottom of the stair		smoke and heat detectors. On	
	without an intermit	tent landing. The	1	the smoke detection system is	<i>i</i>

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/07/2022	
X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTO CROSS-REFERENCED TO TH		INDIANA AVE	E (X5) COMPLETIC DATE		
allowable maximu landings. d) the stair by roon width and not the width. Based on record re correction, the fac alarm system prior a passing score on 06/29/22. Based of Administrator at th had not completed This finding was r Administrator at th This deficiency was	foot distance exceeded the m 12-foot distance between n 201 only had a 30-inch clear required minimum 36-inch clear eview of the facility's plan of ility planned to upgrade the fire r to 09/05/22 in order to achieve the FSES conducted on on an interview with the Interim ne time of interview, the facility if the fire alarm system upgrades. eviewed with the Interim ne exit conference at 11.50 a.m. as cited on 06/06/22. The facility nt a systemic plan of correction nee.		installed, it will give these zon a passing FSES score, including the stairwell. Installation has been delayed plan review and SafeCare obtaining the necessary equipment to complete the smoke detection system. Based on FSES scoring, additional work will need to b done to upgrade the smoke detection system. Total Coverage smoke detection includes the installation of automatic smoke detection in all rooms halls, storage areas, basemen attics, lofts, spaces above suspended ceilings, and othe subdivisions and accessible spaces as well as the inside of all closets, elevator shafts, enclosed stairways, dumb wa shafts and chutes (NFPA 72-2 Section 17.5.3.1). The facility hired the compan SafeCare, to designate areas requiring additional smoke detection coverage. They will also upgrade the Fire Alarm System. SafeCare will submit the necessary paperwork to to Indiana State Department of Health and Homeland Securit for the design release. There	l by be s, nts, er of aiter 2010 hy, hy,	

	MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		OMB NO. 0938-0	
	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 09/07/2022	
	ROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE VN POINT, IN 46307		
(X4) ID	SUMMADY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
				no changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan review will not be necessary per Amy Kelley at Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull station and relay modules with a completion date of December 2022. Once the install has be completed Life safety will be notified to give certification of completed engineer plans.	n v / ns 5, en	
				A new FSES survey was conducted on 6/29/22 by RTM completed paperwork include		
				SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colon is attempting to get a list of th needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contact Koorsen Fire Co. to see if the would be able to complete the project sooner, which they	ne o e ved V	

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DAT	E SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		_	COMPLETED 09/07/2022	
NAME OF P	ROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP N INDIANA AVE	COD		
COLONIA	L NURSING HOM	1E		WN POINT, IN 46307			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	could not (response		DATE	
				No definite start date given at this time. Th estimated time to co project is 3-4 weeks.	e can be hey mplete the		
				The project is estin start in October of 2 the availability of pa facility is committed installation of the Co Smoke Detection Sy described above to b performed by SafeCo will give the building score in the FSES.	nated to 022 pending rts. The to the omplete rstem be are. This		
				Milestones Colonial nursing representative/desig communicate with v Care at minimum 2 t month for updates a developments r/t per project.	endor Safe imes per nd		
				Colonial Nursing representative/desig report update of stat of pending project m the 15th of each mon with each new devel until project is comp Reporting will be in email and reference	tus to ISDH nonthly by nth and opment olete. writing by Survey ID.		
				by email when parts received by Vendor	are		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUII		nstruction 01		DATE SURVEY
		155733	B. WING		<u></u>	_	9/07/2022
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP (NDIANA AVE	COD	
COLONIA	L NURSING HOM	1E			N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COL	RRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIC DATE
					complete project. No when project begins project is complete.		
				How the facility will other residents havir potential to be affect same deficient practi what corrective actio taken?	ng the ed by the ice and		
					Potentially 6 residen upper floor could be The above remedies potential stairways a smokeproof enclosu	affected. cover all nd	
					What measures will place or what system changes the facility v ensure the deficient does not recur?	natic vill make to	
					The Maintenance Di be educated on the p FSES paperwork for Safety binder.	oroper	
					How the corrective a will be monitored to deficient practice wil i.e., what quality assu program will be put in	ensure the I not recur, urance	
					Proper FSES paperw reviewed in QAPI me least a quarterly basi	eting on at is.	
					By what date the sys changes will be com		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		01	COMPLETED 09/07/2022	
	ROVIDER OR SUPPLIE			119 N	ADDRESS, CITY, STATE, ZIP COD		
COLONIA	AL NURSING HON	IE		CROW	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
					2/15/23		
< 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testin Water-based Fire Records of syste inspection and tes secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.6 Based on record re failed to ensure that throughout the fact indicated in the pla practice could affee in therapy. Findings include: Based on interview Interim Administra Director at 12:14 p	RKS information on non-required or partial er system.	К 0.	353	K353 Sprinkler System maintenance and testing What corrective action(s) accomplished for those re found to have been affects the deficient practice? The residents and staff in identified area were not ha the alleged deficient pract 2 areas identified by the s were patched by the Direct Maintenance using 5/8 dry give the area 1 hour prote	will be sidents ed by the armed by ice. The urveyor ctor of /wall to	10/07/2022

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 09/07/2022	
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
COLONI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C audit of the sprink surrounding them correction. This finding was r Administrator and the exit conference This deficiency was	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION ler heads and the ceiling as indicated in the plan of eviewed with the Interim the Maintenance Director at e at 12.25 p.m. as cited on 06/06/22. The facility nt a systemic plan of correction	ID PREFIX TAG	IN POINT, IN 46307 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) Create a smooth continuous ceiling. This has been visualized by I. and CMS life safety surveyor 9/7/22 How the facility will identify of residents having the potential be affected by the same defice practice and what corrective a will be taken? No other residents were affect by the alleged deficient practif facility wide audit of sprinkler heads and the ceiling surrour them was completed by the Maintenance Director to ensure that there was a smooth, continuous ceiling. No other a were found. What measures will be put into place or what systematic char the facility will make to ensure deficient practice does not react An in-service was done with t Director of Maintenance on the proper ceiling space around a sprinkler head. An audit tool we created to monitor the ceiling surrounding sprinklers. Contracted vendor completed facility wide audit on 9/27/22 a reviewed findings with maintenance director and administrator. Sprinkler heads were cleaned and serviced as	SDH on ther to scient action ted ce. A ading areas to nges e the cur? he he a a was d a and s	
				indicated. How the corrective action(s) w monitored to ensure the defic practice will not recur, i.e., wh quality assurance program wi	ient nat	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		COMPLETED 09/07/2022	
NAME OF	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP	COD	
	AL NURSING HON			NINDIANA AVE WN POINT, IN 46307		
	Т			1		1
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAU	REGULATORI U	R ESC IDENTIL TING INFORMATION	IAG	put into place?		DAIL
				The Director of Mainte Designee will conduct 5 random sprinkler he building to ensure tha surrounding ceiling m guidelines of a smoott surface. The audit will conducted weekly tim monthly times five. Th been added to the TE for ongoing monitoring The facility will conduc document monthly au sprinkler heads and th around the sprinkler h ensure the sprinkler h ensure the sprinkler s operates as designed sprinkler response tim inhibited by holes or g Ongoing, the administ designee will monitor ceiling/sprinkler syste continued compliance the monitoring will be during the facility's Qu Assurance meeting; m will be ongoing. By what date the syste changes will be comp	t an audit of eads in the t the eets NFPA h continuous l be es 4 then his audit has LS system g. ct and dits of he ceiling heads to ystem and he is not gaps. trator or the m to ensure e. Results of reviewed uality nonitoring	
(0355 SS=E Bldg. 01		-		10/7/22		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 09/07/2022 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 accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on interview and record review, the facility K 0355 K355 Portable Fire 10/07/2022 failed to ensure portable fire extinguishers were Extinguishers properly maintained in accordance with NFPA 10, What corrective action(s) will be Standard for Portable Fire Extinguishers. This accomplished for those residents deficient practice could affect 6 residents and staff found to have been affected by on the second floor the deficient practice? The residents and staff in the Findings include: *identified area were not harmed by* the alleged deficient practice. The Based on interview and record review of the "2022 fire extinguisher in the wall recess Life Safety Audits" with the Interim Administrator was attached to the wall using a and the Maintenance Director at 12:14 p.m. on mounting bracket. 09/07/22, the facility was unable to provide a This has been visualized by ISDH monthly audit for August to ensure the and CMS life safety surveyor on compliance of five fire extinguishers in the 9/7/22 and state fire marshal on building as indicated in the plan of correction. 9/13/22 with no deficit findings. How the facility will identify other This finding was reviewed with the Interim residents having the potential to Administrator and the Maintenance Director at be affected by the same deficient the exit conference at 12.25 p.m. practice and what corrective action will be taken? This deficiency was cited on 06/06/22. The facility No other residents were affected failed to implement a systemic plan of correction by the alleged deficient practice. A to prevent recurrence. facility wide audit of fire extinguishers was completed by 3.1-19(b) 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **DQE222** Facility ID: 000360 Page 15 of 23 If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> B. WING		COMPLETED 09/07/2022	
NAME OF N			STREET	ADDRESS, CITY, STATE, ZIP CO	D	
NAME OF P	ROVIDER OR SUPPLIE	SK		INDIANA AVE		
COLONIA	L NURSING HOM	ΛE	CROW	/N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PROPRIATE	COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				extinguishers according		
				guidelines. An audit tool		
				created to ensure that the		
				extinguishers are prope	-	
				according to NFPA guid		
				How the corrective action		
				monitored to ensure the		
				practice will not recur, i. quality assurance progra		
				put into place?		
				The facility will conduct	and	
				document monthly audit		
				extinguishers to ensure		
				extinguishers operate as		
				and immediately availab	-	
				Ongoing, the administra	tor or	
				designee will monitor po	ortable fire	
				extinguishers to ensure		
				compliance. Results of t		
				will be reviewed during	-	
				Quality Assurance meet	-	
				monitoring will be ongoi	-	
				The audit tool will be co	•	
				the Director of Maintena designee weekly times f		
				monthly times five to en		
				random fire extinguisher		
				building are being prope		
				This information will be	-	
				the QA meeting. This au		
				also been added to the		
				system.		
				By what date the system		
				changes will be complet	ted?	
				10/7/22		
0363 SS=E	NFPA 101 Corridor - Doors					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	X3) DATE SURVEY COMPLETED 09/07/2022	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO INDIANA AVE	DD	
COLON	AL NURSING HO	ME		N POINT, IN 46307		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION
TAG Bldg. 01	Corridor - Doors	DR LSC IDENTIFYING INFORMATION	TAG			DATE
	than required en exits, or hazardo of smoke and an solid-bonded cor capable of resist minutes. Doors i compartments a passage of smol to rooms contain combustible mat hardware. Roller CMS regulation. apply to auxiliary flammable or cor Clearance betwe covering is not e doors complying if provided with a the door closed w applied. There is closing of the do release when the permitted. Nonra unlimited height meeting 19.3.6.3 frames shall be I other materials in unless the smok sprinklered. Fixe allowed per 8.3. there are no rest resistance of gla assemblies. 19.3.6.3, 42 CFF 483, and 485 Show in REMAR	corridor openings in other closures of vertical openings, us areas resist the passage e made of 1 3/4 inch e wood or other material ing fire for at least 20 in fully sprinklered smoke re only required to resist the ke. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not v spaces that do not contain mbustible material. een bottom of door and floor xceeding 1 inch. Powered with 7.2.1.9 are permissible a device capable of keeping when a force of 5 lbf is s no impediment to the ors. Hold open devices that e door is pushed or pulled are ited protective plates of are permitted. Dutch doors 0.6 are permitted. Door abeled and made of steel or n compliance with 8.3, e compartment is d fire window assemblies are In sprinklered compartments rictions in area or fire ss or frames in window				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 09/07/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE devices. etc. Based on observation and interview, the facility K 0363 K363 Corridor-Doors 10/07/2022 failed to ensure 3 of over 5 corridor doors in the What corrective action(s) will be basement had no impediment to closing and accomplished for those residents latching into the door frame. This deficient found to have been affected by practice could affect 6 residents in the Therapy the deficient practice? room. The residents and staff in the identified area were not harmed by Findings include: the alleged deficient practice. The areas identified by the surveyor, Based on observations with the Interim therapy room, social service and Administrator and the Maintenance Director on administrator office were 09/07/22 from 12:16 p.m. to 12:20 p.m., the immediately corrected, and doors following corridor doors in the basement were were closed. propped open with a wedge: How the facility will identify other 1. the Therapy Room residents having the potential to 2. the Administrator office be affected by the same deficient 3. The Social practice and what corrective action Services/Admissions/Activities/Maintenance will be taken? Director's office No other residents were affected Based on interview at the time of the by the alleged deficient practice. observations, the Maintenance Director agreed All residents have the potential to the aforementioned corridor doors were propped be affected. An audit of corridor open and stated he wasn't aware the doors were doors was complete and any not allowed to be propped open. impediment to door closure was corrected. This finding was acknowledged by the Interim What measures will be put into Administrator and the Maintenance Director at place or what systematic changes the exit conference at 12:25 p.m. 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 on door closures and proper maintenance to prevent impediment to corridor door closure. Doors were inspected for proper functioning and staff were educated to utilize and monitor proper door closure and not prop doors open with any device. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **DQE222** Facility ID: 000360 Page 18 of 23 If continuation sheet

10/13/2022

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	R MEDICARE & MEDI			CONCERNICETION	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y 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)	(X5) COMPLETION DATE
IAU		K LSC IDENTIFYTING INFORMATION		How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., whe quality assurance program will put into place? The Director of Maintenance of Designee will conduct an audi 3 random corridor doors in the building to ensure that doors a closed or opened properly. Th audit will be conducted weekly times 4 then monthly times five This information will be review the QA meeting at least quarter By what date the systemic changes will be completed? 10/7/2022	vill be ient at at I be or t of e are he / e. ved in
K 0522 SS=D Bldg. 01	heating plant, is of combustible math device, and has a and shut down e excessive tempe fuel fired, the dev * is chimney or v * takes air for con * provides for a co from occupied ar 19.5.2.2 Based on interview failed to ensure 1 of the intake combus fuel fired dryers. The create an atmospheric	ting Device ce, other than a central designed and installed so erials cannot be ignited by a safety feature to stop fuel quipment if there is rature or ignition failure. If vice also: ent connected. mbustion from outside. ombustion system separate	K 0522	K522 HVAC- Any Heating Device What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice?	ents

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 09/07/2022	
NAME OF PROVIDER OR SUPPLIER		119 N	ADDRESS, CITY, STATE, ZIP CO INDIANA AVE /N POINT, IN 46307	D		
COLONI (X4) ID PREFIX TAG	(EACH DEFICIE <u>REGULATORY O</u> in the laundry room Findings include: Based on interview Life Safety Audits and the Maintenan 09/07/22, the facil monthly audit for . compliance of the fuel fired dryers as correction. This finding was r Administrator and the exit conference This deficiency was	* STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION n. v and record review of the "2022 " with the Interim Administrator cc Director at 12:14 p.m. on ity was unable to provide a August to ensure the indicated in the plan of eviewed with the Interim the Maintenance Director at at 12.25 p.m. as cited on 06/06/22. The facility t a systemic plan of correction		IN POINT, IN 46307 PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY No residents were identit being harmed by the alled deficient practice. The p. cardboard was immediar removed while the surver present allowing fresh and into the dryer room from This has been visualized ISDH and CMS life safet on 9/7/22 How the facility will ident residents having the pot be affected by the same practice and what correct will be taken? No other residents were by the alleged deficient p. This is the only laundry affacility. No other areas in building required checking What measures will be p. place or what systemation the facility will make to end deficient practice does in An in-service was done of Director of Maintenance laundry staff on the proping ventilation and dangers air intakes. An audit tool created to ensure that the monitored and not obstru- preventing fresh air intak- How the corrective action monitored to ensure the practice will not recur, is end quality assurance programes.	ULD BE PROPRIATE COMPLET DATE DATE died as aged iece of tely iece of tely by the ty surveyor tify other ential to deficient ctive action affected practice. area in the n ng. put into c changes ensure the not recur? with the and per of blocking was nis area is ucted xe. n(s) will be deficient e., what	
				put into place? The facility will conduct a document monthly audit air intakes in the laundry	s of fresh	

	NT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIE		•	119 N	ADDRESS, CITY, STATE, ZIP C INDIANA AVE /N POINT, IN 46307	COD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and conditions. Fire d and unexpected conditions, at lea The staff is famili aware that drills a routine. Where d 9:00 PM and 6:00	the transmission of a fire simulation of emergency fire lrills are held at expected times under varying st quarterly on each shift. ar with procedures and is are part of established lrills are conducted between			with gas-fired dryers to intakes remain clear. O administrator or design monitor these areas to for combustion is taken outside to ensure conti compliance. Results of monitoring will be revie the facility's Quality As meeting; monitoring wil ongoing and this task f added to the TELS sys The audit tool will be c the Director of Mainter designee weekly times monthly times five to e the air intake in the lau not obstructed allowing air intake. This informa reviewed in the QA me least quarterly. By what date the syste changes will be comple 10/7/2022	Dingoing, the nee will o ensure air in from inued f the ewed during ssurance ill be has been stem ompleted by hance or a four then insure that undry area is g for proper ation will be beeting at		

10/13/2022 PRINTED:

	T OF HEALTH AND HU R MEDICARE & MEDI				FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
	155733		B. WING		09/07/2022
		۵. م	STREET	ADDRESS, CITY, STATE, ZIP COD	
AME OF	PROVIDER OR SUPPLIE	SK	-	INDIANA AVE	
OLON	IAL NURSING HON	ЛЕ	CROV	VN POINT, IN 46307	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	audible alarms.				
	19.7.1.4 through				
		eview and interview, the facility	K 0712	K712 Fire Drills	10/07/202
		of 1 August fire drills included		What corrective action(s) will	
		transmission of the fire alarm		accomplished for those reside	
	-	toring station in fire drills		found to have been affected l	by
		n 6:00 a.m. and 9:00 p.m. for the		the deficient practice?	
	•	SC 19.7.1.4 requires fire drills in		All residents could potentially	
	-	incies shall include the		harmed by the alleged deficie	ent
		fire alarm signal and simulation		practice. A fire drill will be	~
		conditions. This deficient		conducted during the day shi	
	as staff and visitor	practice affects all residents in the facility as well		6/24/22. All proper steps will	be
	as stall and visitor	8.		followed and the monitoring	will
	Findings include:			company will notified of the d	////.
	Findings include.			How the facility will identify of	hor
	Based on record re	eview of titled "Fire Drill Report"		residents having the potential	
		dministrator and the		be affected by the same defic	
		ctor on 09/07/22 at 10:59 a.m.,		practice and what corrective	
		acted on $08/31/22$ didn't include		will be taken?	
		e fire alarm signal. Based on		All residents could potentially	be
		ne of record review, the		affected by the alleged deficie	
		ctor confirmed that the		practice. An audit of the drill	
	transmission of ala	arm did not occur on the		conducted on 6/24/22 will dor	ne to
	aforementioned fin	re drills.		ensure that proper protocol w	
				followed and the monitoring	
	This finding was r	eviewed with the Administrator		company was notified. compl	ete
	and Maintenance I	Director at the exit conference at		What measures will be put in	to
	12.25 p.m.			place or what systematic cha	nges
				the facility will make to ensure	e the
	-	as cited on 06/06/22. The facility		deficient practice does not re-	cur?
	failed to implement	nt a systemic plan of correction		An in-service was done with t	he
	to prevent recurren	nce.		Director of Maintenance on th	
				proper fire drill and notificatio	
	3.1-19(b)			procedures. An audit tool was	
	3.1-51(c)			created to ensure that all fire	
				are conducted properly. This	tool

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DQE222

Facility ID: 000360

is also added to TELS for continued monitoring. Additional education was provided to

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULT A. BUILD B. WING	IPLE CONSTRUCTION ING <u>01</u>	СОМ	(X3) DATE SURVEY COMPLETED 09/07/2022	
NAME OF PROVIDER OR SUPPLIER		1	IREET ADDRESS, CITY, STATE, ZIP 19 N INDIANA AVE	COD			
COLONIA	AL NURSING HOM	/IE	C	ROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH AG DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
				Maintenance director drills are pushed to s proper notification on required intervals. How the corrective at monitored to ensure practice will not recur quality assurance pro put into place? The facility will condu document monthly at fire drills to ensure dr documentation of the of the alarm signal. C administrator or desig monitor fire drills to e documentation is cor Results of the monitor reviewed during the f Assurance meeting; f ongoing and has bee the TELS system The audit tool will be the Director of Mainte designee monthly tim ensure that all fire dri were properly conduc monitoring company If there are any errors another drill will be co ensure proper proceed followed. This inform reviewed in the QA n least quarterly. By what date the sys changes will be comp 10/7/22	ervice for all shifts at ction(s) will be the deficient r, i.e., what ogram will be act and udits of the rills include transmission Ongoing, the gnee will nsure the nplete. oring will be facility Quality monitoring en added to completed by enance or nes six to ills that month cted, and the was notified. s identified onducted to dures are ation will be neeting at		