

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155733	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2015
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NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/25/15</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>At this Life Safety Code survey, Colonial Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility is a two story fully sprinklered building determined to be Type V (111) construction with a lower level located in the basement with additions and updates made prior to March 1, 2003. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0025 SS=E Bldg. 01	<p>the corridors, and C hall first floor resident rooms. All other resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 55 and had a census of 40 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between</p>	K 0025	<p>1. Upon surveyor notification of the alleged deficient practice, the cited smoke barrier penetrations were sealed in accordance with 8.3.</p> <p>2. All smoke barrier walls in the facility have been observed to ensure they are in compliance.</p> <p>3. A Quality Assurance Audit has been put into place to ensure to ensure that all penetrations caused by the passage of wire or conduit are protected to maintain smoke barriers. Additionally, a contractor check in sheet has</p>	09/24/2015

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K 0029 SS=D Bldg. 01	<p>the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of five smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director and Administrator on 08/25/15 at 12:49 p.m. and again at 12:53 p.m., the first floor C Hall smoke barrier wall had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a 1.5" hole to allow cables to pass through. Furthermore, the basement smoke barrier wall had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a 7/8" hole to allow cables to pass through. Based on interview at the time of each observation, the Maintenance Director and Administrator acknowledged each aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in</p>		<p>been put into place to ensure all contractors are responsible for sealing all penetrations that are caused by work conducted.</p> <p>4.The aforementioned audit will be completed by the Maintenance Director on a weekly basis. The results of this audit will be submitted to the Quality Assurance Committee on a monthly basis for no less than 6 months.</p>		

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K 0038 SS=F Bldg. 01	<p>accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchen, a hazardous area, was provided with a self closer and latched into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation on 08/25/15 at 11:28 a.m., the corridor door entering the kitchen from the service hall failed to positively latch into the frame. Based on interview, the Maintenance Director and Administrator confirmed the corridor door entering the kitchen from the service hall failed to positively latch into the frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 0029	<p>1. Upon surveyor observation and notification of this requirement, the corridor door to the kitchen was equipped with a self-closure and tested to latch into the frame.</p> <p>2. The facility is equipped with a single door from the kitchen into the corridor area. Therefore the facility is confident that there are no like circumstances.</p> <p>3. An audit has been put into place to ensure that the self-closing door to the kitchen is in working order and that it continues to positively latch into the frame.</p> <p>4. The aforementioned audit will be completed by the Maintenance Director on a weekly basis and submitted to the Quality Assurance Committee Monthly for no less than 6 months.</p>	09/24/2015

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	<p>Based on observation, the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 in 2 of 3 egress paths. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 08/25/15 at 11:52 p.m. with the Maintenance Director and Administrator, the egress path through the 1st floor stairwell to the lower level grade exit were provided with two delayed egress locks. The doors into the stairwells as well as the doors leading to the exit discharge were each provided with a delayed egress lock device. Also, a code was not posted for the 1st floor stairwell exit. Based on interview at the</p>	K 0038	<p>1.As it relates to a double locked egress,although the second door automatically releases when the fire system isengaged, a 15 second release is scheduled to be installed on Tuesday, September8, 2015.</p> <p>2.The facility is equipped with a single double egress,therefore the facility is confident that there are no like circumstances.</p> <p>3.The 15 second release on the double egress doorworking properly has been added to the weekly safety rounds to be completed bythe facility Maintenance Director or designee.</p> <p>4.The results of these rounds will be submitted tothe Quality Assurance Committee on a monthly basis for no less than 1 year.</p>	09/24/2015

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K 0046 SS=F Bldg. 01	<p>time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency light for 5 of 5 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 08/25/15 during the tour from 10:57 a.m. to 12:57 p.m., exterior light fixtures were observed at all exits and there were no exterior emergency battery operated lights or the lights provided were not connected to the emergency generator.</p> <p>Based on an interview with the Maintenance Director and Administrator at the time of each observation, power would not be provided to these exterior</p>	K 0046	<p>1. Upon surveyor notification of this requirement a contractor was contacted and is scheduled to run multiple lines to the required egress lighting on Tuesday, September 8, 2015</p> <p>2. The facility is equipped with a single natural gas generator and five means of egress.</p> <p>3. The facility is confident that by making the aforementioned corrective actions the alleged deficient practice will not recur.</p> <p>4. The exterior lighting will be tested quarterly by the Maintenance Director in conjunction with the monthly load test to ensure said lighting is in working order. The results of this test will be submitted to the Quality Assurance Committee on a quarterly basis for no less than 1 year.</p>	09/24/2015

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K 0050 SS=C Bldg. 01	<p>light fixtures in the event of a power failure and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" forms with the Maintenance Director and Administrator on 08/25/15 at 9:39 a.m., four sequential third shift fire drills took place between 11:15 p.m. and 12:45 a.m. for four of the last four quarters. Based on interview at the time of record review, the Maintenance Director and Administrator acknowledged the aforementioned</p>	K 0050	<p>1.As it relates to third shift fire drills, the facility is unable to retrospectively address the cited concern.</p> <p>2.After a complete review of all current fire drill records the facility is confident there are no like circumstances.</p> <p>3.A schedule has been created that outlines times for each fire drill to take place in two hour increments. The facility Maintenance Director will be responsible for ensuring the monthly fire drills are held at unexpected times under varying conditions in accordance with the facility fire drill schedule.</p> <p>4. The results of this audit will be submitted to the Quality Assurance Committee on a monthly basis for no less than 6</p>	09/24/2015

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K 0064 SS=E Bldg. 01	<p>condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 third floor portable ABC class fire extinguisher pressure gauge readings was in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect up to 16 residents and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/25/15 at</p>	K 0064	<p>months.</p> <p>1.Upon surveyor observation of 1 of 3third floor portable ABC fire extinguishers being "undercharged" the citedextinguisher was removed and replaced with a new fire extinguisher.</p> <p>2.Each ABC and K fire extinguisher inthe facility has been checked by the facility Maintenance Director to ensureall gauges read in the operable range. No like circumstances were identified.</p> <p>3.An audit tool has been put into placein which the Maintenance Director will responsible for checking all fireextinguishers on a monthly basis to ensure all pressure gauge readings remainin the operable range.</p> <p>4.The results of the aforementionedaudit will be submitted to the Quality Assurance Committee monthly for no lessthan 6 mos.</p>	09/24/2015

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K 0066 SS=E Bldg. 01	<p>12:25 p.m., the third floor stairwell fire extinguisher gauge indicated the extinguisher was undercharged. The last monthly inspection was done on 08/03/15. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 area where smoking was not</p>	K 0066	1. Upon surveyor notification of the requirement for a metal container with a self-closing cover device a receptacle meeting this	09/24/2015

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K 0144 SS=F Bldg. 01	<p>permitted for staff and residents was maintained and the metal container with a self-closing cover was used as an ashtray. This deficient practice could affect at least 20 residents and facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observation on 08/25/15 at 11:02 a.m. with the Maintenance Director and Administrator, there were at least 25 cigarette butts on the ground in the Backyard Smoking Area which contained a "smokers oasis", which was a plastic container with a long neck used for cigarette butts. Based on record review, the facility provided a policy indicating smoking was not allowed. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure the load testing for the past 9 of 12 months</p>	K 0144	<p>requirement was placed in the designated smoking area. Additionally, all cigarette butts have been removed from the building grounds.</p> <p>2. A round of the grounds was completed by the Administrator and Maintenance Director any cigarette butts that were identified have been removed.</p> <p>3. The area 15 feet away from the building has been clearly identified as the designated staff smoking area. An in-service has been completed with staff related to the facility smoking policy and how failing to comply with said policy will affect individual employment.</p> <p>4. Daily, smoking audits will be completed by the facility Administrator or designee. The results of these audits will be submitted to the Quality Assurance Committee for review for no less than 6 mos.</p> <p>1. The facility is unable to retrospectively address the lack of documentation for the previous year. However, a load bank test</p>	09/24/2015			

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	<p>indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review of the "Emergency Generator - Monthly Test Log Year" with the Maintenance Director and Administrator on 08/25/15 at 10:31</p>		<p>was completed on September 1, 2015 and it met the 30% requirement. A new annunciator panel is scheduled to be installed on September 8, 2015.</p> <p>2. The facility is equipped with a single natural gas generator. Therefore, the facility is confident that no like circumstances are present.</p> <p>3. An updated monthly generator log has been put into place. This log includes all required testing and documentation. The Maintenance Director will be responsible for the completion of said monthly testing and accurate documentation.</p> <p>4. The results of the monthly generator testing will be submitted to the Quality Assurance Committee monthly for no less than 6 months.</p>	

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	<p>a.m., the generator test log showed 30 percent of the EPS nameplate rating was 3.6 kW. Nine of ten months were shown to have less than 30 percent of the EPS nameplate rating. Two months of documentation was not available for review. Also, no documentation was available for the transfer time. Based on an interview with the Maintenance Director at the time of record review, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 35 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection,</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Administrator on 08/25/15 at 10:31 a.m., no weekly generator testing documentation was available to review prior to 11/3/14 and after 7/8/15. Based on interview at the time of record review, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2015
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K 0147 SS=D Bldg. 01	<p>continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 08/25/15 at 10:31 a.m., the generator annunciator panel located at the first floor nurses' station was not provided with a test button. The Maintenance Director was sent to turn the generator switch to off. The Administrator confirmed that the generator annunciator panel did not alarm when the generator was switched to off. The Maintenance Director was then directed to start the generator. The Administrator confirmed the generator annunciator panel light indicating the generator is running, did not light up.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70,</p>	K 0147	1.As it relates to surge protectors in the business office, upon surveyor observation, the dehumidifier was plugged intofixed wiring. The "piggybacked" surge protector	09/24/2015

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	<p>National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director and Administrator on 08/25/15 between 1:05 p.m. to 1:46 p.m. the following was discovered:</p> <p>a) a surge protector was powering another surge protector powering computer equipment and another surge protector was powering a dehumidifier in the Business office.</p> <p>b) an extension cord was powering computer components in the Director of Nursing office</p> <p>Based on interview at the time of observations, the Maintenance Director and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>was removed a single surge protector was put into use. As it relates to the use of an extension cord in the DONs office. The extension cord had been removed and replaced with fixed wiring.</p> <p>2. A complete round of all office spaces available in the facility have been observed. No like circumstances were identified.</p> <p>3. Proper use of surge protectors and extension cords present has been added to the weekly safety rounds audit.</p> <p>4. The aforementioned audit will be completed by the facility Maintenance Director and submitted to the Quality Assurance Committee on a monthly basis for no less than 6 months.</p>	