			1			T	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	i '		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	
		155733	B. WIN	G		12/16/	2022
			<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			NDIANA AVE		
COLONIA	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	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
D. 1 . 00							
Bldg. 00							
		he Investigation of Complaints	F 000	00	By submitting the enclosed		
	IN00395293 and IN	N00396866.			materials, we are not admittin	•	
	a 11	5000 0 1			truth or accuracy of any speci		
		5293 - Substantiated.			findings or allegations. We res		
		iencies related to the			the right to contest the finding	s or	
	allegations are cited	a at F/32.			allegations as part of any		
	Comm1-1-4 D10000	4966 Substantint 1			proceedings and submit these	9	
	-	6866 - Substantiated.			responses pursuant to our		
		iencies related to the			regulatory obligations. The fac	CILITY	
	allegations are cited	d at F684 and F9999.			requests that the plan of correction be considered our		
	Survey dates: Dece			allegation of compliance effect			
	Facility number: 000360 Provider number: 155733				January 8, 2023. We respectf	-	
					request paper compliance for	this	
					survey resolution.		
	AIM number: 1002	290370					
	Census Bed Type:						
	SNF/NF: 31						
	Total: 31						
	10001						
	Census Payor Type	::					
	Medicare: 3						
	Medicaid: 23						
	Other: 5						
	Total: 31						
	These deficiencies	reflect State Findings cited in					
	accordance with 41	0 IAC 16.2-3.1.					
	Quality review con	npleted on 12/20/22.					
- 000 <i>i</i>							
F 0684	483.25						
SS=E	Quality of Care	_					
Bldg. 00	§ 483.25 Quality of						
		a fundamental principle that					
	applies to all treat	ment and care provided to					
			<u> </u>				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE		TITLE		(X6) DATE

(X6) DATE

Jennifer Short Administrator 01/06/2023

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.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
		155733	B. WI	NG		12/16/	/2022
	PROVIDER OR SUPPLIE		•	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ORRECTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	facility residents.	Based on the					
	comprehensive a	ssessment of a resident, the					
	facility must ensu	re that residents receive					
	treatment and care in accordance with						
	professional stan	dards of practice, the					
	comprehensive p	erson-centered care plan,					
	and the residents' choices.						
			F 06	584	F684 [E] Quality of Care		01/08/2023
		view and interview, the facility			It is the practice of Colonial		
	_	eatments and care in			Nursing and Rehab that resid	ents	
	accordance with professional standards of				receive treatment and care in		
	practice and the comprehensive care plan, related				accordance with professional		
	to lack of an assessment of pain prior to the				standards of practice, the		
	administration of pain medications by a Licensed				comprehensive person-cente	red	
		sment of the effectiveness of			care plan, and the residents'		
	_	n after the the administration,			choices.		
		reviewed for a risk for pain care			What corrective action(s) will		
		E, F, and G) The facility also			accomplished for those reside		
		pain medications as ordered			found to have been affected b	) <i>y</i>	
	for resident D.				the deficient practice;		
					Residents D, E, F, G physicia		
	Findings include:				were notified of assessments	not	
					being completed prior to the		
		cord was reviewed on 12/16/22			administration of pain medica		
		agnoses included, but were not			and the assessing of effective	ness	
	limited to, dementi	a and spinal stenosis.			after the administration of		
		D + G + O (DC)			medication. The physician for		
		num Data Set (MDS)			resident D was also notified o	<b>1</b>	
		11/10/22, indicated a severely			pain medication not being		
		, frequent pain was present,			administered as ordered.		
		n opioid pain medication daily			How other resident having the		
	the past seven days	<b>.</b>			potential to be affected by the		
	A C Di i i	4/11/10 : 1: 4 1 1 : .			same deficient practice will be		
		4/11/18, indicated chronic pain			identified and what corrective		
	•	nterventions included, the pain			action(s) will be taken;		
		be administered as ordered, the			All residents that are ordered		
		e notified if pain medications			routine and/or PRN pain	14-	
		vere not effective, and pain			medication have the potential	το	
	assessment would	be completed as needed.			be affected by the deficient		
	l				practice. Audits were conduct	ea	İ

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155733	B. W	ING		12/16	/2022
				CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
COLONII	AL NUIDOINO LIONA	_			NDIANA AVE		
COLONIA	AL NURSING HOM	<u> </u>		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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Order, dated 11/3/22, indicated			on the orders and medication		
	Percocet (narcotic p	pain medication) 5-325			administration records of those	е	
		ne tablet was to be given every			residents on pain medications	to	
	12 hours for chronic	c pain.			ensure pain assessments wer	e in	
					place prior to administration a		
		ministration Record (MAR),			monitoring of effectiveness of	the	
		cated the Percocet had been			medication. All medication rec		
		m. and 8 p.m. The Controlled			were also audited to ensure pa	ain	
	_	ted the Percocet had been	1		medication was being		
		and 5 p.m. on November 26,	1		administered as ordered.		
	27, 28, 29, and 30, 2022				What measures will be put into	0	
					place and what systemic chan	_	
	The MAR, dated 12/2022, indicated the Percocet				will be made to ensure that the		
		red at 8 a.m. and 8 p.m. The			deficient practice does not rec	:ur;	
	_	ecord, indicated the Percocet			The policy for medication		
		red at 9 a.m. and 5 p.m. on			administration was reviewed b	•	
	December 1 -9, 202	22.			the IDT team. An in-service wa	as	
					conducted with the licensed		
	_	on 12/16/22 at 11:31 a.m., the			nurses and QMA's on pain		
	_	(DON) indicated the Percocet			assessment by the nurse prior		
	had not been given	every 12 hours as ordered.			administration of pain medicat	ion,	
					effectiveness monitoring and		
		rder, dated 11/3/22, indicated			administering medications as		
	_	one tablet could be given			ordered. A Performance		
	1	eeded (prn) for chronic pain, in			Improvement Tool has been		
	addition to the ever	y 12 hour pain medication.			developed that audits		
	TT 0 11 15	D 1 1 1 4 1			assessments of pain prior to a		
		g Record, indicated a prn			after medication administration		
		on 12/12/22 at 5 a.m., 12/15/22			and accurate administration of	Γ	
	1 -	cet administration had not			pain medication .		
	been documented o				Hamitha as we still a settle of	1 6 -	
		cord(MAR), dated 12/2022.			How the corrective actions will		
		assessment of the pain prior to of the medications and no			monitored to ensure the defici	епт	
					practice does not recur;	o o l	
	medication.	ffectiveness of the pain			A performance improvement to		
	medication.				has been initiated that random	ııy	
	The MAD detail 10	2/2022 indicated a non-Danas act			checks three (3) residents to		
		2/2022 indicated a prn Percocet			ensure that they are being	_	
		n 12/13/22 at 2:23 p.m. for pain.			assessed for pain prior to afte		
	There had been no	pain assessment or	1		administering pain medication		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/16/2022		
	PROVIDER OR SUPPLIEF		119 N	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307		
	SUMMARY (EACH DEFICIENT REGULATORY OF effectiveness of the completed by a Lice.  There were no paint the Nurses' Progrest Percocet had been at 2. Resident E's receat 9:10 a.m. The dialimited to, osteoarth A Quarterly MDS at indicated an intact of present, and no opic the past seven days.  A Care Plan, dated was present due to a included, pain medit Physician would be effectiveness of the observed.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION pain medication assessment ensed Nurse.  assessments documented in s Notes indicating why the prn administered.  ord was reviewed on 12/16/22 agnoses included, but were not arritis.  assessment, dated 9/24/22, cognitive status, no pain was bids had been administered in	119 N	INDIANA AVE	AR s will of r four ve (5) her sue and ated. rance	
	be administered ever pain (prn).  The Controlled Dru Tramadol was given p.m., 11/24/22 at 3 p.m. and 8 p.m., and no documentation of that indicated the T assessment of the p pain medication had Licensed Nurse.	pain medication) 50 mg was to ery six hours as needed for a Record indicated the non 11/23/22 at 2 p.m. and 8 p.m. and 9 p.m., 11/28/22 at 2 d 11/29/22 at 8 p.m. There was not the MAR, dated 11/2022, ramadol had been given. An ain and effectiveness of the d not been completed by a regretary and regretary at 8 a.m. The				

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155733		00	CON	TE SURVEY MPLETED 16/2022
	PROVIDER OR SUPPLIER  IAL NURSING HOME	119 N I	ADDRESS, CITY, STATE, ZIP CO NDIANA AVE N POINT, IN 46307	D	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	signature was not legible. The Tramadol was not documented on the MAR and an assessment of the pain and effectiveness of the pain medication had not been completed.				
	There was no documentation in the Nurses' Progress Notes an assessment of the pain, pre-authorization was given, and the Tramadol had been given on November 23, 24, 28, and 29, 2022.				
	The Controlled Drug Record indicated the Tramadol had been administered on 12/1/22 at 2 p.m. and 8 p.m., 12/5/22 at 8 p.m., 12/6/22 at 2 p.m., 12/9/22 at 3:30 p.m. and 9:30 p.m., 12/13/22 at 3 p.m. and 9 p.m. and 12/15/22 at 8 p.m. there was no documentation on the MAR, dated 12/2022, indicating the Tramadol had been given. There had been no assessment of the pain or the effectiveness of the pain medication completed by a Licensed Nurse.				
	The Controlled Drug Record indicated the Tramadol had been administered 12/12/22 at 8 a.m. The MAR indicated the medication had been given. There was no assessment of the pain and effectiveness of the pain medication completed by a Licensed Nurse.				
	There were no documented assessments of the pain or rationale for administration of the Tramadol in the Nurses' Progress Notes.				
	3. Resident F's record was reviewed on 12/16/22 at 10:50 a.m. The diagnoses included, but were not limited to, osteoarthritis.				
	A Quarterly MDS assessment, dated 11/8/22, indicated a moderately impaired cognitive status, no pain was present, and had not received an				

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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 <u>00</u>	(X3) DATE SURVEY COMPLETED 12/16/2022	
	ROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Even days.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	A Care Plan, dated chronic pain was prindicated the effection interventions would a Physician's Order hydrocodone (narcomg, one tablet every administered as need to the Controlled Drushydrocodone had be at 3 p.m. and 8 p.m. 11/29/22 at 7 p.m., were no assessment effectiveness of the by a Licensed Nurse. The MAR, dated 12 hydrocodone had be 7:11 p.m. The pain effectiveness of the Licensed Nurse. The Controlled Drushydrocodone had be 7:11 p.m. The pain effectiveness of the Licensed Nurse. The Controlled Drushydrocodone had be medication on 12/3, at 3 p.m. and 8 p.m. administration had a MAR, dated 12/202 assessments and effi medication assessments and effi medication assessments.	1/19/22, indicated acute and resent. The interventions iveness of the pain I be evaluated.  1. dated 3/20/22, indicated offic pain medications) 5-325 by six hours for pain could be ded.  1. dated 3/20/22, indicated the office pain medicated the office pain medicated the office pain interest.  1. dated 3/20/22, indicated be deen administered.  1. dated 3/20/22 at 3 p.m. and 8 p.m., and 11/30/22 at 3 p.m. and 8 p.m., and 11/30/22 at 3 p.m. There are of the pain and pain medications completed een administered 12/12/22 at had not been assessed and the pain medication by a			
		iagnoses included, but were not			

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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  00	(X3) DATE SURVEY COMPLETED 12/16/2022	
	PROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION al vascular disease and stroke.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	An Annual MDS as indicated an intact of received an opioid of days.  A Care Plan, dated The interventions in would be administed A Physician's Order Norco (narcotic pair table every eight home).	sessment, dated 12/9/22, cognition, had no pain, and every day in the past seven  2/18/29, indicated chronic pain. accluded, the pain medications			
	was signed out on 1 p.m., 12/2/22, 12/3 at 2 p.m. and 10 p.m. 12/10/22 at 10 p.m. p.m. There was no dated 12/2022, the 1 There had been no p	2/1/22 at 11 p.m., 12/2/22 at 7 /22 at 2 p.m. and 10 p.m., 12/4/22 n., 12/8/22 at 1:30 a.m., 12/9/22, , 12/13/22, and 12/15/22 at 8:30 documentation on the MAR, Norco had been administered. pain assessments and effectiveness by a Licensed			
	been given on 12/12 2:35 p.m. There had	2/2022, indicated the Norco had 2/22 at 2:36 p.m. and 12/24/22 at d been no assessment of the ess of the pain medication by a			
		•			
		on 12/16/22 at 10:13 a.m., LPN d been no Licensed Nurse the as needed pain			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r /		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 12/16/2022	
		155733	B. Wl	ING		12/16/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  119 N INDIANA AVE  CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	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	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medications for Res	idents F and G.					
	Director of Nursing	on 12/16/22 at 10:43 a.m. the acknowledge the missing assessments on the MARs assessments.					
	the Director of Nurs current, indicated if administered, docum Pain Management F must also be comple effectiveness of the	inagement policy, provided by sing on 12/16/22 at 12 p.m. as a PRN pain medication was mentation was required on the flow Sheet and documentation eted on the MAR. The medication was to be minutes after the medication					
	received from the D indicated documents the MAR immediate PRN medications w reason, and follow to	n administration policy, prirector of Nursing as current, ation was to be completed on all after the administration. Here to have the date, time, appresults documented.  ates to Complaint IN00396866.					
F 0732 SS=C Bldg. 00	§483.35(g)(1) Data must post the follo basis: (i) Facility name. (ii) The current dat (iii) The total numb worked by the follo licensed and unlice	Staffing Information. a requirements. The facility wing information on a daily					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	
		155733	B. WING			12/16/	2022
	PROVIDER OR SUPPLIER		11	9 N INE	DRESS, CITY, STATE, ZIP COD DIANA AVE 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	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
TAG	(A) Registered nui (B) Licensed practivocational nurses law). (C) Certified nurse (iv) Resident cens §483.35(g)(2) Pos (i) The facility must data specified in psection on a daily each shift. (ii) Data must be posterior (A) Clear and react (B) In a prominent residents and visit §483.35(g)(3) Pubstaffing data. The written request, mavailable to the put to exceed the com §483.35(g)(4) Fact requirements. The posted daily nurse minimum of 18 mostate law, whicheved the constant of the put of the	rises.  Itical nurses or licensed (as defined under State e aides. Iting requirements. It post the nurse staffing baragraph (g)(1) of this basis at the beginning of costed as follows: dable format. It place readily accessible to cors.   F 0732	F I	F732 [C] Posted Nurse Staffing	9	01/08/2023	
	residents who reside	he potential to affect all of the ed in the facility.		ļ r	Nursing and Rehab to post and provide accurate staffing posts required for all licensed staff		
	and 10:46 a.m., the	ration on 12/15/22 at 8:33 a.m. posted daily nursing staffing 2/9/22, 12/12/22, and 12/13/22.		1 1 1	working in the building What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice; Accurate nursing schedule pos	nts y	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/16/2022 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 The staff member responsible for scheduling was posted immediately and indicated on 12/15/22 at 11:11 a.m., she had just reflected proper information posted the correct dates for the daily nursing How other resident having the schedules. She had not worked 12/14/22 and no potential to be affected by the one had posted the hours over the past weekend. same deficient practice will be identified and what corrective 2. The Nursing Schedules from 11/1/22 through action(s) will be taken: 11/13/22 and 12/1/22 through 12/15/22 were All residents have the potential to reviewed on 12/15/22 at 2:30 p.m.. be affected by the deficient practice. The nursing schedule will On 11/6/22, there was a Day Shift Nurse who had be posted each day and updated not shown for work as scheduled and a Day and each shift as changes in staffing Evening Shift CNA who had called in sick. The occur. Daily Nursing Staffing Post had not been updated What measures will be put into with the changes. place and what systemic changes will be made to ensure that the On 11/9/22, a Day Shift CNA had called off. The deficient practice does not recur; Daily Nursing Staffing Post had not been updated The protocol for the posting of with the changes. nursing staffing has been reviewed by the IDT team. An in-service On 11/13/22, a QMA was scheduled for the Day was conducted with licensed Shift and was not listed on the Daily Nursing nurses on information required for Staffing Post. posting and updating prior to each shift as scheduling changes On 12/6/22, a Day Shift CNA and Evening Shift occur. A performance CNA had called off. The Daily Nursing Staffing improvement tool has been Post had not been updated with the changes. developed that audits compliance with posting and updating the On 12/7/22, an Evening Shift CNA had called off. schedule each shift The Daily Nursing Staffing Post had not been How the corrective actions will be updated with the changes. monitored to ensure the deficient practice does not recur; On 12/9/22, an Evening Shift CNA had called off A performance improvement tool and there were three Night Shift CNA's scheduled. has been initiated that will be The Daily Nursing Staffing Post was not posted review the daily posting of the with the correct hours. nursing schedule to ensure that the information is accurate. This On 12/10/22, a Day Shift CNA had called off. The Quality Assurance Audit Toll will Daily Nursing Staffing post was not updated with be completed by the Director of the change. Nursing/ Designee Weekly for four

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155733	B. W	ING		12/16/	/2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Administrator acknown not updated with ch	on 12/16/22 at 12:58 p.m., the owledged the postings were anges.  ates to Complaint IN00395293.			(4) weeks; then monthly for five months. In the event any furth concerns are identified the issemillable immediately corrected additional training will be initial. Results of the audit will be reviewed at the Quality Assuration Meeting at least quarterly.  By what date the systemic changes will be made: January 2023	er ue and ted.	
F 9999							
Bldg. 00	3.1-25 PHARMAC	Y SERVICES	F 9	999	F9999 [3.1-25] Pharmacy Services		01/08/2023
	including alcoholic concentrates, and the be as ordered by the	tion of drugs and treatments, beverages, nutrition erapeutic supplements, shall e attending physician and by a licensed nurse as			It is the practice of Colonial Nursing and Rehab that a Licensed Nurse will be notified assess the resident, and pre-authorize as needed (PRN pain medication administered QMA's. What corrective action(s) will be	l) by	
	administered only u licensed nurse or ph nurse or physician r authorization to adn	od (PRN) medications may be pon authorization of a sysician. All contacts with a not on the premises for minister PRNs shall be nursing notes indicating the contact.			accomplished for those reside found to have been affected by the deficient practice; Residents D, E, F, G physician were notified of the licensed n not supervising PRN medication being distributed by QMA How other resident having the	nts y ns urse ons	
		not met as evidenced by:			potential to be affected by the same deficient practice will be		
		riew and interview the facility deensed Nurse was notified,			identified and what corrective		
		t, and pre-authorization was			action(s) will be taken; All residents who receive PRN	ı	
		as needed (PRN) pain			pain medications have the	ı	
	obtained prior to an	as needed (1 KIV) paill	1		pain medications have the		I

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155733	B. W	ING		12/16/	/2022
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE 7IB COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD NDIANA AVE		
COLONII	AL NILIDQINIC LIONA	E					
COLONIA	AL NURSING HOM			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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ninistered by QMA's for 4 of 5			potential to be affected by the		
		for prn pain medication			deficient practice. An audit wa	S	
	administration by a	QMA. (Residents D, E, F, and			completed on all residents tha	t	
	G)				receive PRN pain medications	and	
					physicians were notified if the		
	Findings include:				deficient practice was noted.		
					What measures will be put into		
		ord was reviewed on 12/16/22			place and what systemic chan	iges	
		agnoses included, but were not			will be made to ensure that the	е	
	limited to, dementia and spinal stenosis.				deficient practice does not rec		
					The QMA scope of practice wa	as	
	1	ders, dated 11/3/22, indicated			reviewed by the IDT team. An		
	Percocet (narcotic pain medication) 5-325				in-service was conducted with	all	
		ne tablet was to be given every			nurses and QMA's to review the	he	
		e pain and Percocet 5-325 mg,			guidelines. A performance		
		given every 24 hours as			improvement tool was develop	oed	
		ronic pain, in addition to the			that audits compliance with		
	every 12 hour pain	medication.			authorization for administration	n	
					was obtained after nurse		
	· ·	tion Administration Record),			assessment of pain.		
		eated a prn Percocet was			How the corrective actions will	l be	
		MA 2 on 12/13/22 at 2:23 p.m.			monitored to ensure the defici	ent	
	1 -	out of 10 and was effective.			practice does not recur;		
		igned out on the Controlled			A performance improvement to	ool	
		/13/22 at 2 p.m. A Licensed			has been initiated that random	ıly	
		sed the resident's pain nor			checks three (3) residents to		
	authorized the admi	inistration of the prn Percocet.			ensure that prn medications a		
					being supervised by a license		
		g Record, indicated a prn			nurse. This Quality Assurance		
		nistered by QMA 2 on 12/15/22			Audit Toll will be completed by		
	1 -	cet was not documented on the			Director of Nursing/ Designee		
	_	not assessed by a Licensed			Weekly for four (4) weeks; the		
		ness of the Percocet was not			monthly for five (5) months. In		
	· · ·	ensed Nurse had not			event any further concerns are	Э	
	authorized the admi	inistration of the prn Percocet.			identified the issue will be		
					immediately corrected and		
		nentation in the Nurses'			additional training will be initia	ted.	
	I -	ssessment/pre-authorization,			Results of the audit will be		
		d been given on 12/12/22,			reviewed at the Quality Assura	ance	
	12/13/22 and 12/15	/22.			Meeting at least quarterly.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/16/2022		
	PROVIDER OR SUPPLIEF			119 N II	NDDRESS, 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)	TE	(X5) COMPLETION DATE
	2. Resident E's rec	ord was reviewed on 12/16/22 agnoses included, but were not			By what date the systemic changes will be made: Januar 2023	y 8,	
	Tramadol (narcotic	r, dated 8/22/22, indicated pain medication) 50 mg was to ery six hours as needed for					
	Tramadol was give p.m. and 8 p.m., 11 11/28/22 at 2 p.m. a There was no docur 11/2022, that indica given. There was no a Licensed Nurse h	ne Tramadol on the MAR or the					
	Progress Notes an a pre-authorization w	mentation in the Nurses' assessment of the pain, as given, and the Tramadol November 23, 24, 28, and 29,					
	Tramadol had been 12/1/22 at 2 p.m. ar	ag Record, indicated the administered by QMA 2 on ad 8 p.m., 12/6/22 at 2 p.m., a and 9:30 p.m., 12/13/22 at 3 d 12/15/22 at 8 p.m.					
	the Tramadol had b Nurse had assessed approval of the Tra 12/6/22, 12/9/22, 12 The MAR indicated	2/2022, had no documentation been given and a Licensed the pain and had given madol to be given on 12/1/22, 2/13/22 at 3 p.m., and 12/15/22. If the Tramadol had been given 22 at 9:04 p.m., there was no					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155733	B. WI	ING		12/16/	/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	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	·		TAG	DEFICIENCY)	\\\L	DATE	
	assessment by the I authorization from	cicensed Nurse and no prior the Licensed Nurse.					
	The Controlled Drug Record, indicated the						
		administered by QMA 4 on					
		The MAR indicated the					
		n given. There was no					
	Licensed Nurse.	or authorization from the					
		mentation in the Nurses'					
	Progress Notes an assessment of the pain and						
	pre-authorization was given by the Licensed  Nurse for the above dates.						
	Nurse for the above	e dates.					
	3. Resident F's record was reviewed on 12/16/22 at 10:50 a.m. The diagnoses included, but were not						
	limited to, osteoarth	_					
	A Physician's Order, dated 3/20/22, indicated						
	1 -	otic pain medications) 5-325					
	mg, one tablet every administered as nee	y six hours for pain could be ded.					
		1/2022, indicated the					
	hydrocodone had no	ot been administered.					
		g Record, indicated QMA 2					
		te hydrocodone on 11/19/22 at					
		11/20/22 at 3 p.m. and 8 p.m., and 11/30/22 at 3 p.m.					
	11/29/22 at / p.m.,	anu 11/30/22 at 3 p.m.					
	There were no asses						
	1 ^	completed by a Licensed Nurse					
	on the above Nover	nber dates and times.					
		2/2022, indicated one					
	hydrocodone had been administered by QMA 2						
		p.m. The pain was rated at a 6					
	and the medication	was effective. There was no	I				1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL	COMPLETED	
155733		B. W	ING		12/16/	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			NDIANA AVE		
COLONIAL NURSING HOME			CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)			DATE		
	documentation that indicated a Licensed Nurse						
		nd had given pre-authorization					
	for the pain medicar	for the pain medication to be given.					
	The Controlled Day	The Controlled Drug Record, indicated QMA 2					
		e medication on 12/3/22 at 2					
		2/4/22 at 3 p.m. and 8 p.m.,					
	12/14/22 at 3 and 9						
		1					
	There were no asses	ssments and					
	1 ~	completed by a Licensed Nurse					
	on December 3, 4, a	and 14, 2022.					
	4 D 11 (C)	1 12/16/22					
		ord was reviewed on 12/16/22 iagnoses included, but were not					
		al vascular disease and stroke.					
	minited to, periphera	ar vascular disease and shoke.					
	A Physician's Order	r, dated 7/14/22, indicated					
	Norco (narcotic pain medication) 5-325 mg, one						
	table every eight ho	ours as needed for pain.					
		g Record, indicated the Norco					
	1	2/3/22 at 2 p.m. and 10 p.m. by					
	QMA 2, 12/4/22 at	2 p.m. and 10 p.m. by QMA 2.					
	There was no docur	mentation on the MAR, dated					
		was administered on the above					
		o pain assessments and					
	Licensed Nurse pre-	-authorization for the Norco to					
	be administered on	12/3/22 and 12/4/22.					
		11.014.2					
		ninistered by QMA 2 on					
		p.m., 12/4/22 at 2 and 10 p.m.,					
	·	m., and 12/14/22 at 2:35 p.m. 2/14/22 was documented on the					
		no Licensed Nurse pain					
		e-authorization given from the					
	Nurse.	addionization given nom the					
	There were no asses	ssments of the pain and					
	I		ı				l l

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED				
		155733	B. WING		12/16/2022				
NAME OF F	DDOWIDED OF CLIPPLIES		STREET .	ADDRESS, CITY, STATE, ZIP COD					
NAME OF F	PROVIDER OR SUPPLIER	X		119 N INDIANA AVE					
COLONIAL NURSING HOME			CROWN POINT, IN 46307						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5)				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		COMPLETION				
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
	_	authorization in the Nurses' Progress Notes							
	for the above dates.								
	_	v on 12/16/22 at 10:05 a.m., LPN							
		nd been no Licensed Nurse							
		e as needed pain medications							
	for Residents D and	d E.							
	During an interview	v on 12/16/22 at 10:13 a.m., LPN							
	_	ad been no Licensed Nurse							
		e as needed pain medications							
	for Residents F and	-							
	101 Residents 1 and	. G.							
	During an interviev	v on 12/16/22 at 10:43 a.m. the							
	_	g acknowledge the missing							
		assessments on the MARs							
	and the lack of asse								
		the Licensed Nurse when							
		ed the pain medications.							
	,								
	The "Indiana State	QMA Scope of Practice",							
		lications were only to be							
		horization was obtained from							
	the facility's license	ed nurse on duty or on call. If							
	-	as obtained, the QMA was to							
		s record was cosigned by the							
		gave permission by the end of							
	the nurse's shift.								
	This state finding re	elates to Complaint							
	IN00396866.								

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