STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155733		03/25/2015

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

(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
F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00169468. Complaint IN00169468- Substantiated. Federal/state deficiencies related to the allegations were cited at F157, F280, and F309. Survey dates: March 24 & 25, 2015 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Survey team: Regina Sanders, RN-TC Census bed type: SNF/NF: 25 NF: 16 Total: 41 Census payor type: Medicare: 6 Medicaid: 26 Other: 09 Total: 41 Sample: 7 These deficiencies reflect state findings	F 000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 27, 2015, by Janelyn Kulik, RN.			
F 157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to timely notify a resident's Physician and Responsible Party of a change in a resident's medical condition, for 1 of 6 residents reviewed for Physician and Responsible Party notification in a total sample of 7. (Resident #F) Finding includes: Resident #F's record was reviewed on 03/24/15 at 12:30 p.m. The resident's diagnoses included, but were not limited to hypertension and atrial fibrillation. An Annual Minimum Data Set assessment, dated 01/21/15, indicated the resident had short and long term memory problems, made poor decisions, had not received a diuretic in the past seven days, and had no shortness of breath. A Nurses' Progress Note, dated 03/04/15 at 1:45 p.m., indicated the resident's Physician had been notified of a PT/INR (blood clotting test) result. The next Nurses' Progress Note, dated	F 157	1. Resident #F – The facility is unable to retrospectively correct the surveyor concern related to this resident. 2. A review of each resident's medical record for the last 30 days has been completed to identify any documented changes in the resident's condition and to determine if the resident's physician and responsible party were made aware of the change in a timely manner. 3. An in-service was immediately provided to the Licensed Professional Nursing Staff regarding the facility's current policy as it relates to notification of the physician and responsible party of any change in resident status. The facility has created a checklist which will be utilized by the Licensed Professional Nursing Staff when identifying a change in resident condition/status. An in-service has been provided to the Licensed Professional Nursing Staff on how to utilize the Resident Change in Condition Checklist. 4. An audit tool has been created to ensure that the responsible party and physician are notified timely of any change in the resident's status. The audit will be completed weekly by the DON/designee. The results of this	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	03/16/15, at 1:15 a.m., indicated, "Resident resting in w/c (wheelchair) sitting straight up c/ (with) O2 (oxygen)/NC (per nasal cannula) @ 3 L (liters). Resident experiences difficulty breathing when in bed even with HOB (head of bed) up (arrow up) 45 (degrees). (R) (respirations) 27 (Normal for 65 years old or older 12-28) shallow, O2 sat (saturation) 97% (normal 92-100%), HR (heart rate) 126 irregular (normal 60-90). B/P (blood pressure) 110/60 (normal 90-120/60-80). Chest upper (arrow up) anterior clear...Mid & lower lobes diminished. 4+ non-pitting edema noted to bil (bilateral) legs...Will continue to monitor." The Nurses' Progress Note lacked documentation to indicate the resident's Physician and Responsible Party had been notified of the change of condition. The next Nurses' Progress Note, dated 03/16/15 at 6:40 a.m., indicated the resident's Physician had been paged and the facility was waiting for a return call. The next Nurses' Progress Note, dated 03/16/15 at 12:05 p.m., indicated the Physician's Nurse had been informed of the resident's decrease in the oxygen saturation and the facility was awaiting a return call from the Physician with		audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters. 5. April 10, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	orders. The next Nurses' Progress Note, dated 03/16/15 at 2:45 p.m., indicated the Physician had returned the call to the facility and orders were received and the Responsible Party had been notified (13 1/2 hours later). A Physician's Order, dated 03/16/15 at 2:45 p.m., indicated an order for oxygen at 3 liters per nasal cannula as needed if oxygen saturation was lower than 90% and to monitor the resident's oxygen saturation levels every shift to maintain the saturation at 90%. A Nurses' Progress Note, dated 03/16/15 at 3:10 p.m. indicated the resident's oxygen saturation was 97% on room air, respirations were unlabored and the resident had denied shortness of breath. A Nurses' Progress Note, dated 03/17/15 at 12:30 a.m., indicated the resident was up walking in the hallway with the CNA. The note indicated, "...Pt (patient) struggling w/c gotten & resident immediately placed in sitting position. Resident dressed in heavy bed time attire. (R) 34, O2 sat 88%, HR 160-193 uncontrolled A-fib (atrial fibrillation). B/P 110/palp (palpitation). Resident changed out of heavy pajamas. Hospital			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	gown in place O2/NC @ 3 L. Resident placed in Broda Chair (high back/reclining wheelchair). V/S (vital signs) now (R) 34. O2 sat 91% HR 140-160. denies chest pain, discomfort. Cont (continue) monitoring." A Nurses' Progress Note, dated 03/17/15 at 1 a.m., indicated, "...(R) 28, (P) 87 O2 sat 91%, B/P 116/palp. O2/NC @ 3 L removed. Will continue to monitor." A Nurses' Progress Note, dated 03/17/15 at 3:05 a.m., indicated the resident's oxygen saturation was 89% and oxygen was started at three liters. There was a lack of documentation to indicate the resident's Physician and Responsible Party had been notified of the change in condition. The next Nurses' Progress Note, dated 03/17/15 at 1 p.m., indicated the resident had no distress, oxygen was being administered at three liters with an oxygen saturation of 92% , respirations were 22, pulse was 74 and irregular and the Physician was paged. (This was 12 hours after the resident had a condition change) The next Nurses' Progress Note, dated 03/18/15 at 9:45 a.m., indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	resident was sitting in a wheelchair, was lethargic and not propelling self in the wheelchair. The Note indicated the Physician was notified and orders were received and the Responsible Party had been notified. A Physician's Order, dated 03/18/15 at 9:45 a.m. indicated orders for laboratory tests due to the change in the resident's health status. A Nurses' Progress Note, dated 03/19/15 (no time documented and identified as 10 p.m. to 6 a.m. shift charting by the Director of Nursing), indicated, "...Resp (respirations) 43-48. Chest is clear. O2 @ 3 L/NC O2 sat 89%. HR irregular at 98. 4+ pitting edema noted bil legs...Pt c/o (complains of) thirst. 8 oz H2O (water) provided. Skin turgor is poor...Will continue to monitor." There was a lack of documentation to indicate the resident's Physician and Responsible Party had been notified of the resident's change of condition. The next Nurses' Progress Note, dated 03/19/15 at 2 p.m., indicated the resident's oxygen saturation was 92% and continued to have edema at 3+ to the bilateral lower extremities.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	There was a lack of documentation to indicate the resident's Physician and Responsible Party had been notified of the resident's change of condition. A Nurses' Progress Note, dated 03/19/15 at 11:30 p.m., indicated the residents heart rate was 58, respirations were above 34, oxygen saturation on room air was 90%, blood pressure was 120/80 and the resident had 3-4+ edema of the lower legs. The next Nurses' Progress Note, dated 03/20/15 at 12:10 a.m., indicated, "...CNA's stated bed alarm sounding...resident out of bed & had ambulated out to dining room & fell...V/S: (R) 34, HR 68, B/P 110/72 O2 sat 88. Pt appear shaken & anxious...O2/NC @ 2 L in place...will continue to monitor." A Nurses' Progress Note, dated 03/20/15 at 12:50 a.m. indicated the resident's Physician had been notified and orders were received to transfer the resident to the Hospital Emergency Room and the Responsible Party had been notified. A Physician's Order, dated 03/20/15 at 1 a.m., indicated to transfer the resident to the Hospital Emergency Room to rule out hypoxia, congestive heart failure and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	atrial fibrillation. A Physician's Order, dated 03/20/15 at 6 a.m., indicated the resident had been admitted into the Hospital with a diagnoses of atrial fibrillation, congestive heart failure, urinary tract infection, and pleural effusion. During an interview on 03/25/15 at 9:54 a.m., the Director of Nursing indicated the resident's Physician and Responsible Party had not been notified timely of the change in the medical status. The Director of Nursing indicated the Nurse should have notified the Physician when the change of condition had occurred on 03/16/15 at 1:15 a.m., 03/17/15 at 12:30 a.m., 03/19/15 on the 10 p.m. to 6 a.m. shift, and 03/19/15 at 2 p.m. A facility policy, dated 04/12, titled, "Change in a Resident's Condition or Status", and received from the Administrator as current, indicated, "...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...e. A significant change in the resident's physical/emotional/mental condition...2. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155733		03/25/2015

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

(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
	(sponsor) when:...b. There is a significant change in the resident's physical, mental, or psychosocial status..." This Federal Tag relates to complaint IN00169468. 3.1-5(a)(2)			
F 280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155733		03/25/2015

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

(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
	representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure Residents' and their Responsible Parties were invited to participate in the planning of care, related to inviting the Resident and/or Responsible Parties only to the annual care plan conference for 3 of 4 residents who resided in the facility for 90 days or more in a total sample of 7. (Residents #B, #E, and #J) Findings include: 1. During a telephone interview on 03/24/15 at 9:10 a.m., Resident #B's Responsible Party indicated there had been an invitation to the resident's care conference, "maybe once". Resident #B's record was reviewed on 03/24/15 at 3:15 p.m. The residents diagnoses included, but were not limited to Alzheimer's disease and hypertension. A Quarterly MDS (Minimum Data Set) assessment, dated 02/10/15, indicated the resident's cognition could not be evaluated and the resident had severely impaired decision making skills. The Care Plan Conference sign sheet	F 280	F280 1. As it relates to Residents # B, E, and J. Each of the Responsible parties have been sent invitations to attend a quarterly care plan review. 2. The facility has sent letters to all of the current residents' responsible parties inviting them to attend a quarterly care plan review at their convenience. Additionally, Social Services has invited all residents that are cognitively intact to participate in a care plan review. 3. A quality assurance audit has been put into place to ensure all Responsible parties and appropriate residents are invited to attend care plan reviews on a quarterly basis. 4. The results of this audit will be reviewed by the Quality Assurance Committee once a month for no less than 6 months. 5. The systematic changes will be completed by April 10, 2015.	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	indicated the resident's care plan conferences were completed on 03/11/14, 06/10/14, 08/28/14, 11/03/14, and 02/10/15. A letter, dated 07/30/14, indicated the resident's Responsible Party was invited to the resident's Care Plan Conference scheduled for 08/21/15. The Interdisciplinary Team Progress Note, dated 07/07/14, indicated the resident's Responsible Party had contacted the facility to indicate they were unable to attend the Care Plan Conference scheduled for August 21, 2014. 2. Resident #E's record was reviewed on 09/25/15 at 10:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and renal failure. The Significant Change MDS assessment, dated 02/26/15, indicated the resident's cognition was intact. The Care Plan Conference sign sheet indicated the resident's Care Plan Conferences were completed on 08/27/14, 09/27/14, 10/03/14, 11/12/14,12/23/14, and 02/26/15.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	There was a lack of documentation to indicate the resident and/or the Responsible Party had been invited to participate in the Care Planning Conferences. 3. Resident #J's record was reviewed on 03/25/15 at 11:51 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The Annual MDS assessment, dated 02/26/15, indicated the resident's cognition was intact. The Care Plan Conference sign sheet indicated the resident's Care Plan Conferences were completed on 06/03/14, 08/22/14, 11/21/14, and 02/20/15. The sheet indicated the resident's Responsible Party had attended the Annual Care Conference on 02/20/15. A Letter, dated 02/10/15, indicated the resident's Responsible Party had been invited to the Care Plan Conference, scheduled for 02/20/15. There was a lack of documentation to indicate the resident and/or the Responsible Party had been invited to the other Care Planning Conferences. During an interview on 03/24/15 at 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/25/2015

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

(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.m., the MDS Coordinator indicated residents' and Responsible Parties were not invited to Quarterly Care Plan Conferences. The MDS Coordinator indicated they are only invited to the Annual Care Plan Conference. This Federal Tag relates to complaint IN00169468. 3.1-35(c)(1)			
F 309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview the facility failed to provide necessary care and services, related to not assessing a resident who had a change in a medical status, for 1 of 6 residents reviewed for	F 309	1. Resident #F – The facility is unable to retrospectively correct the surveyor concern related to this resident. How other resident shaving the potential to be affected by the same deficient practice will be identified and	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	conditions changes in a total sample of 7. (Resident #F) Finding includes: Resident #F's record was reviewed on 03/24/15 at 12:30 p.m. The resident's diagnoses included, but were not limited to hypertension and atrial fibrillation. An Annual Minimum Data Set assessment, dated 01/21/15, indicated the resident had short and long term memory problems, made poor decisions, had not received a diuretic in the past seven days, and had no shortness of breath. A Nurses' Progress Note, dated 03/16/15, at 1:15 a.m., indicated, "Resident resting in w/c (wheelchair) sitting straight up c/ (with) O2 (oxygen)/NC (per nasal cannula) @ 3 L (liters). Resident experiences difficulty breathing when in bed even with HOB (head of bed) up (arrow up) 45 (degrees). (R) (respirations) 27 (Normal for 65 years old or older 12-28) shallow, O2 sat (saturation) 97% (normal 92-100%), HR (heart rate) 126 irregular (normal 60-90). B/P (blood pressure) 110/60 (normal 90-120/60-80). Chest upper (arrow up) anterior clear...Mid & lower lobes diminished. 4+ non-pitting edema noted to bil (bilateral) legs...Will continue to		what corrective action will be taken; 2. When a change in condition is identified the facility will ensure that the resident's condition is assessed and documented in the medical record every four hours for three consecutive days. 3. The facility has created a checklist which will be utilized by the Licensed Professional Nursing Staff when identifying a change in resident condition/status. An in-service has been provided to the Licensed Professional Nursing Staff on how to utilize the Resident Change in Condition Checklist. 4. An audit tool has been created to ensure that once a change in condition has been identified that an assessment is completed and documented every four hours for three consecutive days. The audit will be completed weekly by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters. 5. April 10, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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
	monitor." A Nurses' Progress Note, dated 03/16/15 at 3:10 p.m. indicated the resident's oxygen saturation was 97% on room air, respirations were unlabored and the resident had denied shortness of breath. There were no other assessments of the resident's status from 03/16/15 at 1:15 a.m. through 03/16/15 at 3:10 p.m. A Nurses' Progress Note, dated 03/17/15 at 12:30 a.m., indicated the resident was up walking in the hallway with the CNA. The note indicated, "...Pt (patient) struggling w/c gotten & resident immediately placed in sitting position. Resident dressed in heavy bed time attire. (R) 34, O2 sat 88%, HR 160-193 uncontrolled A-fib (atrial fibrillation). B/P 110/palp (palpitation). Resident changed out of heavy pajamas. Hospital gown in place O2/NC @ 3 L. Resident placed in Broda Chair (high back/reclining wheelchair). V/S (vital signs) now (R) 34. O2 sat 91% HR 140-160. denies chest pain, discomfort. Cont (continue) monitoring." A Nurses' Progress Note, dated 03/17/15 at 1 a.m., indicated, "...(R) 28, (P) 87 O2 sat 91%, B/P 116/palp. O2/NC @ 3 L removed. Will continue to monitor."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	A Nurses' Progress Note, dated 03/17/15 at 3:05 a.m., indicated the resident's oxygen saturation was 89% and oxygen was started at three liters. A Nurses' Progress Note, dated 03/17/15 at 1 p.m., indicated the resident had no distress, oxygen was being administered at three liters with an oxygen saturation of 92% , respirations were 22, pulse was 74 and irregular and the Physician was paged. (This was 12 hours after the resident had a condition change) There were no other assessments of the resident's status from 03/17/15 at 3:05 a.m. through 03/17/15 at 1 p.m. The next Nurses' Progress Note, dated 03/18/15 at 9:45 a.m., indicated the resident was sitting in a wheelchair, was lethargic and not propelling self in the wheelchair. The Note indicated the Physician was notified and orders were received and the Responsible Party had been notified. A Physician's Order, dated 03/18/15 at 9:45 a.m. indicated orders for laboratory tests due to the change in the resident's health status. A Nurses' Progress Note, dated 03/19/15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015

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

(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
	(no time documented and identified as 10 p.m. to 6 a.m. shift charting by the Director of Nursing), indicated, "...Resp (respirations) 43-48. Chest is clear. O2 @ 3 L/NC O2 sat 89%. HR irregular at 98. 4+ pitting edema noted bil legs...Pt c/o (complains of) thirst. 8 oz H2O (water) provided. Skin turgor is poor...Will continue to monitor." There were no other assessments of the resident's status from 03/18/15 at 9:45 a.m. through 03/19/15 on the 10 p.m. to 6 a.m. During an interview on 03/25/15 at 9:54 a.m., the Director of Nursing indicated the resident had no further assessments with the change in status. This Federal Tag relates to complaint IN00169468. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307	

(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