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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	06/30/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00407030, IN00409011, IN00410504, and IN00411495. Complaint IN00407030 - Federal/state deficiencies related to the allegations are cited at F697 and F921. Complaint IN00409011 - No deficiencies related to the allegations are cited. Complaint IN00410504 - No deficiencies related to the allegations are cited. Complaint IN00411495 - Federal/state deficiencies related to the allegations are cited at F660, F661, and F921. Survey dates: June 26, 27, 28, 29, and 30, 2023. Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 2 Medicaid: 26 Other: 5 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered effective July 28, 2023, to the annual licensure survey completed June 30, 2023. The facility also requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Short	Administrator	07/21/2023

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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	Quality review completed on 7/6/23.			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antidepressant medication use for 1 of 13 MDS assessments reviewed. (Resident 188) Finding includes: The record for Resident 188 was reviewed on 6/27/23 at 1:40 p.m. Diagnoses included, but were not limited to, major depressive disorder, hypertension, and anxiety disorder. The Admission MDS (Minimum Data Set) assessment, dated 6/20/23, indicated the resident had not received antidepressant medication in the past seven days. The June 2023 Physician's Order Summary indicated an order for trazodone (an antidepressant medication) 100 mg (milligrams) 2 tabs at bedtime. The June 2023 Medication Administration Record (MAR) indicated the resident received the antidepressant medication as ordered. Interview with the MDS Nurse on 6/29/23 at 1:30 p.m., indicated the MDS was incorrect. The resident had received the antidepressant medication and it should have been marked.	F 0641	Written plan of correction not required for this deficiency. Facility has committed to correct.	07/28/2023

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	3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document			

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	whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on record review and interview, the facility failed to ensure a comprehensive care plan was in place for a resident receiving an antipsychotic medication for 1 of 13 residents whose care plans were reviewed. (Resident 33) Finding includes: The record for Resident 33 was reviewed on 6/27/23 at 11:20 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertension, and osteoarthritis. The Admission MDS (Minimum Data Set) assessment, dated 4/10/23, indicated the resident had received antipsychotic medication in the past seven days. The June 2023 Physician's Order Summary indicated an order for olanzapine (an antipsychotic medication) 5 mg (milligrams) daily. The June 2023 Medication Administration Record (MAR) indicated the resident received the antipsychotic medication as ordered. Interview with the Administrator on 6/27/23 at 3:31	F 0656	F656 [D] Develop/Implement Comprehensive Care Plan It is the practice of this facility to develop a person-centered comprehensive care plan for each resident that includes measurable objectives and timeframes to meet needs identified in the comprehensive assessment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 33 comprehensive care plan was revised to reflect the antipsychotic medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who receive antipsychotic medications have the potential to be affected by the alleged deficiency. An audit was conducted on all physician orders for the use of antipsychotic	07/28/2023

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	p.m., indicated there had not been a care plan for the antipsychotic medication but staff had now initiated one. 3.1-35(a)		medications and care plans reviewed. No further deficiencies were noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; An in-service has been conducted for the MDS coordinator entitled “Care Plans, Comprehensive Person-Centered” to ensure antipsychotic medications are addressed on the care plan. The policy and procedure for care plans was reviewed by the IDT team. A performance improvement tool was developed to audit that antipsychotic medication use is addressed on the care plan. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient’s comprehensive care plan is accurately completed related to antipsychotic medications. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance	

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			Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to ensure a resident was invited to their care plan conference for 1 of 13 residents whose plans of care were reviewed. (Resident 19)	F 0657	F657 [D] Care Plan Timing and Revision It is the practice of this facility that we ensure that comprehensive care plans are developed with the	07/28/2023

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	Finding includes: Interview with Resident 19 on 6/26/23 at 8:59 a.m., indicated she had not been invited to any recent care plan meetings and she could not remember attending one. The record for Resident 19 was reviewed on 6/26/23 at 2:44 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/9/23, indicated the resident was cognitively intact. A Care Plan Note, dated 1/25/23, indicated the IDT (interdisciplinary team) had met with the resident and her daughter. The care plans were reviewed, discussed, and updated. There was lack of documentation the resident had been invited to any care plan meetings or any care plan meetings had been held since 1/25/23. Interview with the Administrator on 6/27/23 at 3:31 p.m., indicated there had been no formal care plan meetings for the resident since January. She met with the resident in February to discuss her payor source and staff met with the resident regularly to discuss concerns, but she was unable to provide any documentation. 3.1-35(c)(2)(C)		participation of the resident and the resident representative to the extent practicable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 19 was invited to a care conference and attended on 07/18/2023. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficiency. On 7/14/23, all residents and families were sent a letter inviting them to participate in a care conference. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The policy and procedure on care conferences was reviewed by IDT. The Social Service designee was in-serviced on the policy “Care Planning – Interdisciplinary Team”. A performance improvement tool has been developed to monitor that patient/responsible parties are being invited to care plans. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) residents to ensure	

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			that patient/responsible parties are being invited to care plans. This Quality Assurance Audit Tool will be completed by the Administrator/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as			

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	defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the			

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	data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on record review and interview, the facility failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions related to lack of planning, education, and supplies for a resident's caregivers on how to care for the resident's ileostomy before the resident's discharge home from the facility for 1 of 1 residents reviewed for ileostomy care. (Resident C) Finding includes: A closed record review for Resident C was completed on 6/28/23 at 1:54 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of the body), hypertension, and seizure disorder. The resident was admitted to the facility on 5/19/23 and	F 0660	F660 [D] Discharge Planning Process It is the practice of this facility that we ensure that residents who are planning to discharge have an effective discharge plan developed and implemented to transition to post-discharge care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C was discharged from the facility. A follow up call was made for Resident C to ensure all supplies and education needed were provided. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents discharging have the	07/28/2023

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	discharged home on 6/24/23. The Admission Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident was cognitively moderately impaired. The resident required an extensive 2+ person assistance with bed mobility, transfers, and toilet use. The resident required an extensive 1 person assistance for locomotion, dressing, eating, and personal hygiene. The resident had an impairment on one side of his upper extremities for functional limitation in range of motion (ROM). The resident had surgical wounds and an ostomy (opening from inside of the body to the outside for passage of bodily waste). A Care Plan indicated the resident had an ileostomy (operation to bring the small bowel through an opening in the belly to move waste out of the body) related to bowel surgery. Interventions included to change the bag after each bowel episode or when full, and to change the wafer as ordered and when indicated. The June 2023 Physician's Order Summary indicated an order for ileostomy care every shift and to change ileostomy appliance every 7 days. An Occupational Therapy (OT) Discharge Summary for 6/23/23 indicated it was recommended the resident had 24 hour care when discharged. A Physician's Note, dated 6/22/23 at 4:46 p.m., indicated the resident had a history of a stroke with residual right upper extremity weakness. The resident had an ileostomy that was new to the resident. The resident would require training on care and maintenance if he was going home.		potential to be affected by the alleged deficiency. A discharge summary will be completed on all residents who plan on discharging. A copy will be provided to the resident/responsible party and documented in the resident chart. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The policy and procedure on transfers/discharges was reviewed by IDT. The Social Service designee and nursing were in-serviced on the policy “Transfer or Discharge – Resident Initiated”. A performance improvement tool has been developed to monitor that resident discharges are planned and include instructions for education and needed supplies. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) discharged residents to ensure that residents are being discharged appropriately. This Quality Assurance Audit Tool will be completed by the Administrator/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated.	

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	A Social Services (SS) Note, dated 6/23/23 at 2:31 p.m., indicated the resident received a NOMNC (Notice of Medicare Non-Coverage) with LCD (Last Covered Day) of 6/23/23. The SS reviewed the notice with the resident. The resident did not want to appeal the notice and was to discharge home on 6/26/23. A Nursing Note, dated 6/24/23 at 2:30 p.m., indicated the resident's brother arrived to the facility. The resident was transferred to home. Medications and paperwork were given to the resident. There was no documentation to indicate the resident's care givers who he was going to live with on discharge had any teaching related to the care of the resident's ileostomy. Interview with Director of Therapy on 6/29/23 at 9:19 a.m., indicated that if he was going home they recommended he had a 24 hour care giver to assist with his ileostomy care. He only had the use of one hand and she was concerned he would be unable to care for the ileostomy on his own. She was unsure if nursing had completed any ileostomy teaching with the resident's care givers. Interview with the Director of Nursing on 6/29/23 at 10:00 a.m., indicated the resident had ileostomy teaching every time it was changed. The plan was for him to discharge home with family. She could not provide any documentation the family was given any instructions or teaching related to the ileostomy care. The nurse should have sent home ileostomy supplies with the resident when he discharged. She could not provide any documentation the supplies were sent home with the resident.		Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	

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	Interview via phone with the Social Services Director on 6/29/23 at 10:09 a.m., indicated she was unsure if nursing had set up and completed any teaching with the resident's care givers before discharge related to ileostomy care. This Federal tag relates to Complaint IN00411495. 3.1-47(a)(3)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been			

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COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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	made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on record review and interview, the facility failed to ensure a discharged resident had a discharge summary completed, including a post-discharge plan of care with the resident and responsible party, for 1 of 2 residents reviewed for discharges. (Resident C) Finding includes: Record review for Resident C was completed on 6/28/23 at 1:54 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of the body), hypertension, and seizure disorder. The resident was admitted to the facility on 5/19/23 and discharged home on 6/24/23. The Admission Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident was cognitively moderately impaired. The resident required an extensive 2+ person assistance with bed mobility, transfers, and toilet use. The resident required an extensive 1 person assistance for locomotion, dressing, eating, and personal hygiene. The resident had an impairment on one side of his upper extremities for functional limitation in range of motion (ROM). The resident had surgical wounds and an ostomy (opening from inside of the body to the outside for passage of bodily waste). The June 2023 Physician's Order Summary (POS), indicated an order for the resident to be discharged home on 6/26/23. A Social Services (SS) Note, dated 6/23/23 at 2:31 p.m., indicated the resident received a NOMNC (Notice of Medicare Non-Coverage) with LCD	F 0661	F661 [D] Discharge Summary It is the practice of this facility to ensure that residents have a discharge summary completed on discharge that includes a post-discharge plan of care with the resident and responsible party. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C was discharged from the facility. A follow up call was made for Resident C regarding discharge plan of care. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents discharging from the facility have the potential to be affected by the alleged deficiency. A discharge summary will be completed on all residents who plan on discharging. A copy will be provided to the resident/responsible party and documented in the resident chart. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The policy and procedure on discharge summaries was reviewed by IDT. The Social Service designee and nursing were	07/28/2023

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	(Last Covered Day) of 6/23/23. The SS reviewed the notice with the resident. The resident did not want to appeal the notice and was to discharge home on 6/26/23. A Nursing Note, dated 6/24/23 at 2:30 p.m., indicated the resident's brother arrived to the facility. The resident was transferred to home. Medications and paperwork were given to the resident. There were no other progress notes or documentation to indicate what medications or paperwork was given to the resident. There was no documentation to indicate a Discharge Summary was completed which included, but was not limited to, a recapitulation of the resident's stay, a final summary of the resident's status at the time of discharge, and a post-discharge plan of care. Interview with the Director of Nursing (DON) on 6/29/23 at 10:00 a.m., indicated she could not provide any documentation a discharge assessment was completed on the resident which would have included medications and supplies that were sent home with the resident. The resident was scheduled to discharge home on 6/26/23 but discharged home on 6/24/23. The nurse should have completed a discharge assessment on 6/24/23 when the resident discharged home. A facility policy titled, "Discharge Summary and Plan" and received as current from the Administrator on 6/30/23, indicated, "...1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility, a discharge summary and a post-discharge plan will		in-serviced on the policy “Discharge summary and plan”. A performance improvement tool has been developed to monitor that discharge summaries are completed and provided on discharge to the resident/representative. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) discharged residents to ensure that resident has a completed discharge summary. This Quality Assurance Audit Tool will be completed by the Administrator/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	

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	be developed which will assist the resident to adjust to his or her new living environment. 2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident's information and as permitted by the resident..." This Federal tag relates to Complaint IN00411495. 3.1-36(a) 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, record review, and interview, the facility failed to ensure a lymphedema sleeve was applied as ordered and a scabbed area was assessed and monitored for 1 of 1 residents reviewed for edema and non-pressure skin conditions. (Resident 25) Finding includes: On 6/26/23 at 12:56 p.m., Resident 25 was observed lying in bed watching television. The resident did not have a lymphedema sleeve	F 0684	F684 [D] Quality of Care It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and resident choices. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	07/28/2023

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	applied to the left arm. The resident had a visible black scabbed area to the base of his 2nd toenail on the left foot. On 6/27/23 at 1:10 p.m., Resident 25 was observed lying in bed watching television. The resident did not have a lymphedema sleeve applied to the left arm. The black scabbed area was still observed to the base of his 2nd toenail on the left foot. Record review for Resident 25 was completed on 6/27/23 at 9:15 a.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation, deep vein thrombosis (DVT), heart failure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 5/3/23, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assistance for bed mobility, transfers, dressing, and toilet use. The resident had an impairment on both sides of his upper and lower extremities for a functional limitation in range of motion (ROM). A Care Plan, dated 4/25/23, indicated the resident was at risk for thrombus/embolus related to a DVT to the left arm. Interventions included to observe for edema, pain, and increased color changes of the effected extremity. A Care Plan, dated 4/24/23, indicated the resident had potential impairment to the skin integrity related to generalized weakness. An intervention included to monitor and document location, size, and treatment of skin injury. Nursing was to report abnormalities to the Physician. The June 2023 Physician's Order Summary, indicated an order to wear a lymphedema sleeve to		Resident 25 no longer has an order for the lymphedema sleeve. The scabbed area on the left 2nd toe has been assessed and is being monitored. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who have edema and non-pressure skin conditions have the potential to be affected by the deficient practice. A review of orders and skin assessments were completed on all residents. No further deficiencies were noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. An in-service has been conducted for the licensed nurses on following physicians orders regarding edema devices and assessment and monitoring of skin conditions. A performance improvement tool was developed to audit that devices ordered for edema are being applied and skin conditions are being assessed and monitored. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that devices for the management of edema are applied and skin	

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	the left arm/hand at all times related to swelling. A Physician's Progress Note, dated 6/20/23 at 4:24 p.m., indicated the resident was seen for a follow up on swelling to the left hand. The resident had 2 to 3+ edema to the left hand. A lymphedema sleeve had been ordered on 6/18/23. A Weekly Skin Review, dated 6/19/23, indicated the resident's skin was intact. There was no documentation to indicate the residents scabbed area had been assessed or was being monitored. Interview with the Director of Nursing on 6/27/23 at 3:03 p.m., indicated nursing should have been applying the resident's lymphedema sleeve. Interview with the Wound Nurse on 6/27/23 at 3:30 p.m., indicated she was previously unaware of the resident's scabbed area to his toe. She went and measured the area and received an order from the Physician to monitor the area. 3.1-37(a)		conditions are assessed and monitored. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 7/28/23	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain medications were available for a newly admitted resident experiencing pain for 1 of 1 residents reviewed for pain management.	F 0697	F697 Pain Management It is the practice that this facility must ensure that pain management is provided to	07/28/2023

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	(Resident B) Finding includes: The closed record for Resident B was reviewed on 6/26/23 at 1:04 a.m. The resident was admitted on 4/21/23, and left against medical advice on 4/22/23. Diagnoses included, but were not limited to, left femur fracture, rectal cancer and spinal stenosis. A 4/21/23 Nursing Admission Assessment indicated the resident had a surgical incision on the left hip with 33 staples. A Physician's Order, dated 4/1/23, indicated to give hydrocodone-acetaminophen, (an opioid pain medication) 7.5 milligrams (mg) /325 mg every 6 hours as needed for pain. A Skilled Nursing Note, dated 4/22/23 at 2:03 a.m., indicated at 10:55 p.m., (4/21/23) a call was placed to the pharmacy for authorization to pull hydrocodone-acetaminophen from the EDK (emergency drug kit), The pharmacist informed the nurse there was no order for the medication, the Physician would have to Escript (electronic prescription) it over. The Physician was paged twice with no response. The nurse gave the resident acetaminophen and apologized to the resident. A Nursing Note, dated 4/22/23 at 5:50 a.m., indicated there had been no response from the Physician. A Nursing Note, dated 4/22/23 at 9:01 a.m., indicated the Nurse Practitioner had been called for an Escript for the pain medication. The resident was rating pain 7 out of 10. The Escript was received by the pharmacy and the resident		residents who require such services, consistent with professional standards of practice, comprehensive person-centered care plans and the residents' goals and preferences. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B has been discharged from the facility. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All newly admitted residents who have orders for controlled pain medications have the potential to be affected by the alleged deficient practice. If a written script is not received on admission and the primary care physician is not available, alternate providers will be contacted if needed (nurse practitioner, medical director) to obtain a script to receive and administer pain medication as ordered. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. An in-service has been conducted for the licensed nurses on ordering and receiving controlled medications for new admissions. All newly hired licensed nurses will be in-serviced prior to starting	

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	was given the hydrocodone-acetaminophen at 9:31 a.m. Interview with the Director of Nursing, on 6/27/23 at 1:30 p.m., indicated that should not have happened. There was another Physician and also Nurse Practitioners available to call for an Escript. This Federal tag relates to Complaint IN00407030. 3.1-37(a)		work. The policy titled “Ordering and Receiving Controlled Medications” was reviewed by the IDT. A performance improvement tool was developed to audit that controlled medications are available for administration. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that audits all new admissions to ensure that controlled pain medications are available for administration. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 7/28/23	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of			

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	licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to have accurate daily nurse staffing postings. This had the potential to affect all 33 residents residing in the facility. Finding includes: On 6/26/23 at 7:50 a.m., the Daily Nursing Staffing Form, dated 6/26/23, was observed posted on the wall near the desk at the main entrance. There	F 0732	F732 [C] Posted Nursing Staffing Information It is the practice of this facility to post nurse staffing data as specified on a daily basis at the beginning of each shift. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	07/28/2023

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	was no daily facility census number listed on the form. On 6/29/23 at 10:15 a.m., the Daily Nursing Staffing Forms, dated 6/1/23 through 6/28/23, were reviewed. The daily facility census number was not listed on any of the forms. Interview with the Administrator on 6/29/23 at 10:27 a.m., indicated she was unsure why the census number wasn't listed on the forms and staff would go over the census in their daily meetings. She would update the forms.		An accurate nursing schedule was posted immediately and reflected proper census information. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. The nursing schedule will be posted each day with the current census. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. · Inservice occurred with scheduling department on postings · Developed new staffing sheet to include daily census · IDT reviewed the policy for posting staffing · A performance improvement tool has been developed to monitor staffing sheets are accurate and have census on the sheet How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) days to ensure that staffing sheets are accurate and have the current census listed. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for	

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			three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote	F 0757	F757 [D] Drug Regimen is Free from unnecessary Drugs. It is the practice that this facility	07/28/2023

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	or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to labs not completed as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 25) Finding includes: Record review for Resident 25 was completed on 6/27/23 at 9:15 a.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation, deep vein thrombosis (DVT), heart failure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 5/3/23, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assistance for bed mobility, transfers, dressing, and toilet use. The resident had an impairment on both sides of his upper and lower extremities for a functional limitation in range of motion (ROM). The June 2023 Physician's Order Summary, indicated the following laboratory orders: - weekly BMP (basic metabolic panel) ordered 5/11/23 - iron studies, Vitamin B12, and folate level on 6/5/23 There was no documentation to indicate the laboratory orders for 6/5/23 had been completed. There was no documentation to indicate the BMP had been completed since 6/2/23. Interview with the Director of Nursing on 6/27/23 at 3:03 p.m., indicated she was unable to find any documentation the above laboratory tests had been completed.		must ensure that each resident's drug regimen is free from unnecessary drugs. Based on a comprehensive assessment of a resident, the facility must ensure that all residents receive medication reviews with current laboratory review orders. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The ordered labs were completed for resident 25 on 05/11/2023. The physician was notified of omission of lab completion on date originally ordered. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with ordered labs have the potential to be affected by the alleged deficient practice. An audit was completed on all residents to ensure labs were completed as ordered and medical practitioner was notified of results. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. · The policy on laboratory testing was reviewed by IDT. · Facility in-service occurred with all nursing staff on lab and diagnostic test results – clinical protocol. New hire orientation to include information regarding pain	

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	155733	A. BUILDING 00 B. WING	06/30/2023

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

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	3.1-48(a)(3)		management and future in-service to occur. · A performance improvement tool has been developed to monitor lab orders and completion. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) residents for completion of ordered labs. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 7/28/23	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.			
	Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs related to not following a recipe for pureed food. This had the potential to affect 1 resident who received a	F 0805	F805 [D] Food in form to meet individual needs It is the practice of this facility to ensure food is prepared in form to meet individual needs.	07/28/2023

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	pureed diet. (Main Kitchen) Finding includes: On 6/29/23 at 11:15 a.m., the Cook was observed preparing pureed cornbread. She indicated she had already made the pureed food for the resident, but would demonstrate how the cornbread was made. She placed a piece of cornbread in the blender, then added some milk. The milk was not measured. There was no recipe in use. She blended the items together. The mixture was thin and soupy. She then took some of the previously prepared pureed cornbread and added it to the mixture in the blender. She indicated there were recipes for everything in the recipe book. The previously prepared pureed cornbread and pureed BBQ riblette were removed from the warming oven. The Cook indicated they were ready to be served. The cornbread was thick and dry. The Dietary Manager (DM) indicated it was too thick. The BBQ riblette was still chunky. The DM indicated it had to be smooth like baby food. The DM placed the BBQ riblette in the blender and ran it through three cycles. It remained chunky, not smooth. He then added some powered food thickener and ran it through three more cycles. He indicated he was not able to get the meat smooth and would have to make an alternate food. There was no recipe in use. The recipes were received from the DM, on 6/29/30 at 2:25 p.m. The Pork Riblette recipe indicated, "...for any of the above modified texture diets: (including pureed) Add small amounts of gravy, sauce, vegetable juice, cooking water, fruit juice, milk or		*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* · The kitchen staff working on 6/29/2023 were in-serviced on following a recipe for pureed food. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* · All residents who receive pureed food have the potential to be affected by the alleged deficient practice. An audit was completed to identify all residents who receive pureed food to monitor that correct consistency food was prepared according to the recipe and was served. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.* · All dietary staff were in-serviced on specialized diets and following recipes · A performance improvement tool has been developed to monitor dietary staff on properly preparing pureed food according to the recipes *How the corrective actions will be monitored to ensure the deficient practice does not recur.* A performance improvement tool has been initiated that randomly audits five (5) meals to monitor	

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	half and half to meet desired consistency...Add commercial thickener if product needs thickening...." The Pureed Cornbread recipe indicated, "...Measure desired # of servings into food processor. Blend until smooth. Add water if product needs thinning. Add commercial thickener if product needs thickening...." 3.1-21(a)(3)		dietary staff are properly preparing pureed food according to the recipe. This Quality Assurance Audit Tool will be completed by the Food Service Director/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made: 07/28/2023*	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based observation, record review, and interview, the facility failed to ensure food was served and stored under sanitary conditions related to unlabeled and expired food in the refrigerator, dirty refrigerator shelves, lack of hand hygiene during food preparation, dirty utensil bins and a broken oven door. This had the potential to affect 30 residents who received food from the kitchen. (The Main Kitchen) Findings include: 1. During the initial kitchen tour on 6/26/23 at 8:07 a.m., the following was observed in the reach in refrigerator with the Dietary Aide (DA): - an open pack of sliced cheddar cheese, undated - an open pack of Swiss cheese, undated - sliced ham, dated 5/22/23 - bag of sliced red onions, undated - open bag of shredded cabbage, with a use by date of 6/21/23 - open pack of breaded fish, undated - open pack of breaded chicken, undated There was liquid spillage and food debris on the refrigerator shelves and on the bottom of the refrigerator. Interview with the DA at the time of the observation, indicated the items should be dated when opened, the expired items were thrown away, and the refrigerator was in need of cleaning. 2. During the follow up visit to the kitchen, on 6/28/23 at 11:15 a.m. the following was observed:	F 0812	F812 [E] Food Procurement, Store/Prepare/Serve- Sanitary It is the practice of this facility to ensure food is served and stored under sanitary conditions. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* · 1:1 in-service held with dietary staff member on donning and doffing of gloves and proper hand hygiene · Opened, undated and expired items in the refrigerator were disposed of. · The refrigerator and shelving were cleaned. · The bins containing utensils were covered. · The oven door is scheduled to be repaired by the vendor. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* · All residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Cleaning and maintenance schedules were initiated to ensure kitchen areas are kept in a	07/28/2023

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	a. The Cook was standing near the stove wearing a pair of disposable gloves. She prepared to make pureed cornbread. Wearing the gloves, she opened the refrigerator and got a gallon of milk. She then opened the oven door and, using her gloved hand, got a piece of cornbread, then opened the blender and placed the cornbread in it, covered and turned it on, all with the same gloved hands. She then added some milk and continued to blend the mixture. The mixture was too thin, so she retrieved a previously made batch of pureed cornbread and scooped some out with her gloved hand and added it to the mixture in the blender. Interview with the Cook at that time, indicated she had not changed gloves or completed hand hygiene as she should have. b. Below the preparation counter, there were two open plastic bins with kitchen utensils. There was visible food debris and crumbs in the bottom of each bin. There was a plastic measuring spoon with a white powder coating it. The Dietary Manager (DM) removed it from the bin and indicated the bins needed to be covered. c. The oven door would not stay closed. The Cook and DM continually closed the door, and it would fall open again. The Cook indicated it had been like that at least since January. Interview with the DM during the observations, indicated he had requested utensil bins with covers as they were crumb catchers. He also indicated the stove door had been broken since he had been there, he had put in a maintenance request, but it had not been fixed yet. He would prop it closed using a sheet pan at times to keep it closed.		sanitary and workable condition. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.* · Policies on food storage, hand hygiene, and glove use was reviewed by the IDT. · All dietary staff were in-serviced on glove donning and doffing, hand hygiene, food storage and cleaning and maintenance schedules. · A performance improvement tool has been developed to monitor alleged deficiencies are being met in the kitchen. *How the corrective actions will be monitored to ensure the deficient practice does not recur.* A performance improvement tool has been initiated that randomly audits five (5) days to monitor safe food storage, cleaning, maintenance and hand hygiene are being met. This Quality Assurance Audit Tool will be completed by the Food Service Director/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance	

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	The policy, "Food Storage", was received from the DM on 6/27/23, indicated, " ...1. Food storage areas should be clean at all times ...." The policy, "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practice", was received from the DM on 6/28/23, indicated, " ...6. Employees must wash their hands: ...f. After handling soiled equipment or utensils; g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. ..." 3.1-21(i)(3)		Meeting at least quarterly. *By what date the systemic changes will be made: 07/28/2023*	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to improper cleaning of reusable equipment for 3 of 4 medication pass observations. (RN 1, LPN 1) Findings include: 1. On 6/28/23 at 9:03 a.m., RN 1 was observed preparing a resident's medications. She placed a wrist blood pressure cuff on the resident's wrist and checked his blood pressure. She then removed the blood pressure cuff and cleaned it using an alcohol prep pad and set it on top of the medication cart. She administered the resident's medications and went on to the next resident. At 9:20 a.m., she prepared the next resident's medications, placed the wrist blood pressure cuff on the resident's wrist, and checked her blood pressure. She then removed the blood pressure cuff and cleaned it using an alcohol prep pad and set it on top of the medication cart. She administered the resident's medications and went on to the next resident. 2. On 6/28/23 at 9:41 a.m., LPN 1 was observed preparing a resident's medications. There was a sign on the resident's door indicating he was on contact isolation. LPN 1 indicated the resident	F 0880	F880 Infection Prevention & Control It is the practice of this facility to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by ensuring infection control guidelines are in place and implemented. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: RN 1 was in-serviced on the proper procedure for cleaning reusable equipment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who are cared for with reusable equipment have the potential to be affected by the alleged deficient practice. Disposable blood pressure equipment has been made available for use in isolation rooms. A supply of appropriate cleaning agents per policy has	07/28/2023

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	was on isolation for C.diff infection (Clostridium difficile, a bacteria). She donned a gown and gloves took the blood pressure cuff from the top of her medication cart and entered the resident's room. She placed the blood pressure cuff on the resident's left arm and checked his blood pressure. She then removed the blood pressure cuff and set it on top of the medication cart, which was in the doorway of the room. She administered the resident's medications, removed her gown and gloves, performed hand hygiene, and exited the room. She pushed her medication cart down the hall and went to assist another resident. She had not cleaned the blood pressure cuff. Interview with the Director of Nursing (DON) on 6/28/23 at 10:42 a.m., indicated there should have been a disposable blood pressure cuff to use in the isolation room. LPN 1 should have cleaned the blood pressure cuff. The nurses were to use a larger sized alcohol wipe to clean the reusable equipment. There was no specific facility policy on cleaning reusable equipment. Interview with the Infection Preventionist on 6/28/23 at 11:26 a.m., indicated the staff should have cleaned the reusable equipment using a Super Sani-Cloth germicidal wipe, not an alcohol prep pad. The DON was completing an inservice currently. 3.1-18(b)		been stocked on the unit carts to clean equipment after use. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The policy on "Cleaning and Disinfection of Resident–Care Items and Equipment" was reviewed. Facility in-service on cleaning reusable equipment was held with all nursing staff. New hire orientation to include information regarding cleaning protocol and future in-service to occur. A performance improvement tool has been developed to monitor equipment cleaning protocols. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) days to monitor reusable equipment cleaning. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 7/28/23	

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F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, record review, and interview, the facility failed to provide a least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208) Findings include: 1. The floor area of the following single resident room measured: a. Room 111 - 1 resident, 96.2 SQ FT. NF. 2. The floor areas of the following multiple resident rooms measured: a. Room 101 - 1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. Room 104 - 0 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. Room 201 - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF. d. Room 202 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. e. Room 204 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. Room 206 - 1 resident, 140.0 SQ FT, 70.0 SQ FT per bed. NF. g. Room 208 - 1 resident, 146.9 SQ FT, 73.4 SQ FT per bed. NF. The facility rooms with room variances were observed on 6/28/23 at 9:50 a.m. The rooms were	F 0912	F912 [E] Bedrooms Measure Least 80sq FT/Resident It is the practice of this facility to ensure that rooms with a variance have single occupancy. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. All rooms have single occupants. Facility records indicate existence of room waiver variance letters from ISDH dating from June 5, 2003, to present ownership. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other residents are affected by this waiver practice. No other resident’s safety is affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · Residents in waived rooms will continue to occupy as single occupants, not double, therefore ensuring their environmental	07/28/2023

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	observed with the following number of beds: Room 101 - 1 bed Room 104 - 1 bed Room 111 - 1 bed Room 201 - 1 bed Room 202 - 1 bed Room 204 - 1 bed Room 206 - 1 bed Room 208 - 1 bed Interview with the Administrator, on 6/29/23 at 9:14 a.m., indicated these were the rooms which had the variance waivers and did not have the required square footage. 3.1-19(l)(2)		safety. How the corrective actions will be monitored to ensure the deficient practice does not recur; · A performance improvement tool has been initiated that randomly audits five (5) waivered rooms weekly to assure they are only being occupied by one person. This Quality Assurance Audit Tool will be completed by the Maintenance Director / Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional, safe, and homelike environment related to bent or loose baseboard heater covers, marred and gouged doors and walls, a ripped and torn wheelchair armrest, loose thermostat cover and broken floor tiles for 4 of 30 resident rooms (Rooms 111, 112, 124 and 202) and 2 of 2 units (first and second floor).	F 0921	F921 [E] Safe/Functional/Sanitary/ Comfortable Environment It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the	07/28/2023

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	155733	A. BUILDING 00 B. WING	06/30/2023

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

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	Findings include: During the Environmental Tour on 6/29/23 from 1:15 p.m.-1:30 p.m. with the Maintenance Supervisor, the following was observed: 1. First floor: a. In Room 111, the baseboard heater cover was bent, loose, and pulling away from the wall. One resident resided in the room. b. In Room 112, the baseboard heater cover was bent and falling off. One resident resided in the room. c. In Room 124, Resident 7's wheelchair armrest was torn and ripped. d. In the dining room, the baseboard heater covers were loose and bent, and the endcap was falling off one end. e. In the hall near the elevator, the thermostat cover was pulled away from the wall and attached by only one screw. d. In the halls, the tile was chipped and broken in several places. f. The resident bathroom door had laminate peeling away from the bottom and a marred doorframe. g. The wall next to the resident bathroom had an area with several small holes and was unpainted. 2. Second floor: a. In Room 202, there were gouges on the wall		deficient practice: · Baseboard heater cover fixed in rooms111 and 112 · Room 124 wheelchair armrest was fixed · Dining room baseboard heater cover and endcap were fixed · Thermostat cover was fixed in the hall near the elevator · Hall tiles were fixed · Resident bathroom door was fixed and door frame painted · Wall with holes was fixed and painted · 202 room wall was fixed and cleaned · Trim surrounding exterior of elevator was fixed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Environmental concerns will be repaired when reported or identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. An in-service was held with all staff on the TELS system for creating work orders. · A performance improvement tool has been developed to monitor the rooms to ensure that	

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	and a black substance on the wall near the bed. One resident resided in this room. b. The trim surrounding the exterior of the elevator had a large piece missing from the bottom. Interview with the Maintenance Supervisor at the end of the tour, indicated the above was in need of repair. This Federal tag relates to Complaints IN00407030 and IN00411495. 3.1-19(f)		environmental concerns are reported and addressed. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) rooms to ensure that the environment is in good condition, including baseboard heaters, wheelchairs, floor tiles, thermostat covers, walls, trims, doors and frames and repairs are completed timely. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights.	F 9999	F 9999 Personnel It is the practice of this facility that we ensure there is an organized ongoing inservice education and training program planned in advance for all personnel. What corrective action(s) will be accomplished for those residents	07/28/2023

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	(5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received screening or education related to tuberculosis at least annually and received the required annual training for 2 of 5 employees reviewed. (CNA 1 and LPN 2) Findings include: The employee records were reviewed on 6/29/23 at 10:00 a.m. and indicated the following: a. CNA 1 had no annual resident rights, abuse, or dementia training or tuberculosis screening/ education completed in 2022. b. LPN 2 had no annual resident rights, abuse or dementia training or tuberculosis screening/ education completed in 2022.		found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the deficient practice. A monthly inservice will be scheduled for all staff that includes annual training on resident rights, abuse, dementia training, and tuberculosis screening/education. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · A yearly calendar was created for scheduling at least one inservice a month to include the required annual training. · A performance improvement tool has been developed to audit that staff have received the required inservice training annually. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) staff to ensure required annual inservice trainings have been completed. This Quality Assurance Audit Tool will be completed by the Human Resources Director/Designee	

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	The Centers for Disease Control and Prevention (CDC) guidance, found at https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm, indicated the following for healthcare staff: " .... Annual Screening, Testing, and Education ... Healthcare facilities might consider using annual TB screening for certain groups at increased occupational risk for TB exposure ... All health care personnel should receive TB education annually. TB education should include information on TB risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures. TB education materials can be found through CDC, the TB Centers of Excellence for Training, Education, and Medical Consultation, NTCAexternal icon, State TB Programs, and the Find TB Resources website." Interview with the Business Office Manager, on 6/28/23 at 1:57 p.m., indicated there were no inservices or tuberculosis education/ screening completed for the above employees in 2022.		weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 07/28/2023	