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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00399626, IN00400138, IN00400247, IN00400504, and IN00401479. Complaint IN00399626 - Substantiated. Federal/State deficiencies related to the allegations are cited at F804. Complaint IN00400138 - Substantiated. Federal/State deficiencies related to the allegations are cited at F804. Complaint IN00400247 - Substantiated. Federal/State deficiencies related to the allegations are cited at F804 and F921. Complaint IN00400504 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F602, F607, F677, F684, and F689. Complaint IN00401479 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Unrelated deficiency is cited. Survey dates: February 17, 20, and 21, 2023 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 32 Total: 32	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 March 16, 2023, to the annual licensure survey completed February 21, 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	03/27/2023

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.

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Census Payor Type: Medicare: 1 Medicaid: 20 Other: 11 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/28/23.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from mental and verbal abuse by staff, related to a CNA using foul language and making derogatory remarks about the resident during care for 1 of 3 residents reviewed for abuse. (Resident E) Finding includes: An Indiana Department of Health (IDOH) reported incident indicated Resident E alleged that CNA 4	F 0600	F600 [D] Free from Abuse and Neglect It is the practice of this facility that we ensure that residents are free from abuse and neglect based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents*	03/27/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had spoken to her in a derogatory manner on 2/19/23 at 5:01 a.m. During an interview on 2/20/23 at 11:10 a.m., Resident S, who was identified as having no cognitive impairment, indicated the night before last she over heard CNA 4 tell Resident E she was too fat and other derogatory remarks. CNA 3 was also in the room and was saying, "uh-huh" to everything CNA 4 was saying. During an interview on 2/20/23 at 11:15 a.m., Resident E indicated CNA 3 and CNA 4 entered her room during the night. CNA 4 was saying how she was tired of cleaning up after one of the evening shift CNA's. She had voiced that the resident was the heaviest wetter she had to take care of. She called her fat. CNA 3 was in the room and agreed with CNA 4 by humming "uh-huh". CNA 4 had called her fat a few weeks ago as well and had said she was big and she was tired of rolling her back and forth at night during care. Resident E also indicated CNA 3 had told her to "shut up" about a month ago. During an interview on 2/21/23 at 1:22 p.m., Resident E indicated it was just CNA 4 who was making the derogatory remarks and had said Resident E was the heaviest bed wetter in the building and she was tired of having to come in and clean her up. She indicated this had been going on for a while and she was tired of it. She indicated it was abuse and she had been fearful to use the call light. CNA 3 would stand back and agree with CNA 4. CNA 4 had said while caring for her, "F*** this, I'm not doing this anymore." The initial facility investigation per the Administrator, indicated on 2/19/23 CNA 3 had been suspended and denied the allegation. CNA 4		*found to have been affected by the deficient practice:* · The administrator entered the allegation on 2/19/2023 made by Resident E into ISDH portal · The administrator investigated the allegation and completed the follow up on 2/24/23. · Resident E physician was notified of the allegation and social service followed up with the resident over a course of three days and will continue to monitor resident throughout stay *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 reside in the facility have the potential to be affected by the alleged deficient practice. · Facility-wide interviews of staff, residents, and families of residents unable to be interviewed were conducted and there were no additional allegations. · All residents unable to be interviewed moods and behaviors unchanged and at baseline. *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 abuse and neglect was reviewed by the IDT · Facility in-service occurred with all staff regarding abuse and	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was interviewed on 2/19/23 and denied the allegation. The resident had been interviewed by the Administrator on 2/20/23 and indicated CNA 4 had been the one making the statements about her size. CNA 4 was then suspended. Resident S was interviewed by the Administrator on 2/21/23 and indicated she had heard CNA 4 making comments to Resident E that she "was too da** big" and she goes through a lot of bed pads. CNA 4 also told the resident she was not going to provide care to her. Resident E's record was reviewed on 2/20/23 at 2:42 p.m. The diagnoses included, but were not limited to, left below the knee amputation and morbid obesity. An Admission Minimum Data Set (MDS) assessment, dated 1/1/23, indicated an intact cognitive status, no behaviors, required extensive assistance of 2 for bed mobility and toileting, was dependent for transfers and bathing, and was incontinent of bowel and bladder. The facility abuse policy, dated 9/2022, indicated the residents had a right to be free from abuse and to be treated with respect and dignity. This Federal tag relates to Complaint IN00400504. 3.1-27(a)(1) 3.1-27(b)		neglect. New hire orientation to include information regarding abuse and neglect, and annual abuse and neglect in-service to occur. · A performance improvement tool has been developed to monitor potential allegations of abuse, staff understanding of the abuse policy and proper reporting. *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 and residents or family of residents that are unable to be interviewed to ensure that they are free from abuse and neglect. 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:* 3/27/2023	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure residents were free from misappropriation of property for 1 of 4 residents observed during medication administration. (Resident K) Finding includes: On 2/17/23 at 10:24 a.m., Nurse 1 was observed preparing medications for Resident K. The medications included atorvastatin (a cholesterol medication) 20 mg (milligrams). Nurse 1 popped the medication out of the card and placed it in the medication cup. At that time, the atorvastatin medication card was observed to be labeled with another resident's name. Nurse 1 was stopped and made aware. Interview with Nurse 1 on 2/17/23 at 10:26 a.m., indicated the other resident's medication card must have been placed in the wrong spot. She found the correct medication card and reviewed it. The medication and the dosage were the same. She indicated she was going to continue to administer the medication already in the medication cup since she had already popped it out, even though it was from the other resident's medication card. Interview with the Director of Nursing (DON) on 2/17/23 at 11:37 a.m., indicated the nurse should have ensured the medication was for the correct resident. She would provide education to the	F 0602	F602 [D] Free from Misappropriation/Exploitation It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Primary physician was made aware. · 1:1 Inservice occurred with the Nurse 1 who performed the medication administration *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 medication have the potential to be affected by the alleged deficiency. · All staff who administered medications were observed to complete a medication pass to ensure that no misappropriation is occurring. No further alleged	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurse immediately. A facility abuse policy, dated 9/2022, and received from the Administrator as current, indicated the residents had a right to be free from misappropriation of resident property. This Federal tag relates to Complaint IN00400504. 3.1-28(c)		deficiencies were identified. *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 medication administration general guidelines were reviewed by IDT. · An in-service with all licensed nurses and QMA's was completed regarding proper medication distribution to prevent misappropriation of medications. · A performance improvement tool has been developed to monitor that medication is administered to the resident identified on the medication label. *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 identity is verified and only their medication is distributed to them. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee Weekly for 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.	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			By what date the systemic changes will be made; 3/16/2023	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, related to employees not screened thoroughly prior to caring for the residents for 2 of 5 employees hired in the past 4 months. (QMA 5 and CNA 6) Findings include: Employee files were reviewed on 2/21/23 at 12:00 p.m. QMA 1 was hired on 2/2/23 and had started working with the residents on 2/6/23. She had worked on February 6, 7, 8, 11, 12, 13, 17, and 20, 2023. The State of Indiana background check, dated 1/19/13 indicated the background check was pending. During an interview on 2/21/23 at 12:09 p.m., the Business Office Manager indicated the background check was pending due to finger printing being required for the employee. She was unsure if the employee had gone to be finger printed. CNA 6 was hired on 11/10/22 and had started working with the residents part time on 11/15/22. There were no references in the file. There were letters in the file, dated 1/3/22, which indicated on 1/3/22, the reference checks were sent out. During an interview on 2/21/23 at 1:39 p.m., the Business Office Manager indicated the references had not been sent out until 1/3/23. The facility abuse policy, dated 9/2022, and	F 0607	F607 [D] Develop/Implement Abuse/Neglect Policies It is the practice of this facility that employees are screened thoroughly prior to caring for the residents. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · No residents were found to be affected by the alleged deficiency 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 alleged deficiency practice. · Facility audit occurred on 3/8/2023 to assure that all employees have had their background checks and references completed. · Facility added abuse acknowledgement form to the orientation process. *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 procedures were reviewed for abuse and neglect by IDT · 1:1 in-servicing occurred with	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	received from the Administrator as current, indicated, "...Abuse Prevention and Protection Guidelines. 1. The facility must no employ or otherwise engage individuals who: Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law...Our facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals...Our abuse prevention program as a minimum provides: Screening - Protocols for conducting employment background checks; background checks include State Criminal...reference checks..." This Federal tag relates to Complaint IN00400504. 3.1-28(a)		Human Resource Director to assure that all new employees are properly screened prior to caring for residents · A performance improvement tool has been developed to monitor that reference and background checks are completed on all employees. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly checks five (5) employee files to ensure that proper screening is completed prior to them working with residents. This Quality Assurance audit tool will be completed by the HR coordinator/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;* 3/16/2023	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure extensive to dependent residents received necessary care and services in a timely manner, related to activities of daily living (ADLs) of incontinent care, meal service, bathing, and call light response for care needed for 4 out of 7 residents interviewed for call light response (Residents E, N, C, and M) and 4 of 4 residents reviewed for ADLs. (Residents E, J, C, and D) Findings include: 1. The following residents were interviewed regarding ADLs and assistance: On 2/17/23 at 9:10 a.m., Resident E indicated she would activate the call light and no one would answer it for long periods of time. On 2/17/23 at 10:31 a.m., Resident N indicated the call light has taken up to 30 minutes to get answered and he has had to transfer himself to the bathroom because it had not been answered timely. On 2/20/23 at 8:30 a.m., Resident C indicated she has waited long periods of time to get assistance with changing the soiled brief or to get help. On 2/21/23 at 8:50 a.m., Resident M indicated she has waited long periods of time for assistance	F 0677	F677 [E] ADL Care Provided for Dependent Residents It is the practice of this facility that we ensure that residents receive necessary care and services in a timely manner related to activities of daily living based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Staff were in-serviced on call light response time to address the allegation from residents E, N, M, and C. · The activity director was in-serviced on tray set up and requesting assistance with duties that require certified staff to address the deficency for resident J. · Resident E, J, C were offered baths/showers per preference and schedule. · Resident D was discharged. *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;*	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with soiled briefs. 2. During an observation and interview on 2/17/23 at 9:10 a.m., Resident E was lying in bed. The head of the bed was raised and the resident had slid down on the mattress so her head was not at the top of the bed. The room had a urine odor and the resident indicated she had a soiled brief. The brief was wet. She indicated she had been waiting 6-8 hours to get the brief changed and the last time someone was in to provide incontinent care was late the past evening. She indicated she had informed a CNA she needed assistance when they brought her breakfast tray in around 8 a.m. and no one had been back to assist her. She indicated she had not received bed baths often and was unable to take a shower at this time. An observation on 2/17/23 at 9:30 a.m., indicated no staff has entered the room to provide care. An observation on 2/17/23 at 10:15 a.m., indicated the resident had been assisted with her daily care. She was dressed, in the wheelchair, and there were no odors. She indicated she was assisted around 10 a.m. The shower schedule indicated bathing was to be completed on Wednesday and Saturday days. The bathing records indicated there had been no bathing between January 11, 2023 and January 16, 2023, between 1/26/23 and 2/1/23, and between 2/8/23 and 2/17/23. Resident E's record was reviewed on 2/20/23 at 2:42 p.m. The diagnoses included, but were not limited to, left below the knee amputation and morbid obesity.		· All extensive to dependent care residents have the potential to be affected by the alleged deficiency. · Facility will monitor call light response time, showering, showering documentation, and meal set up. *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 for adl care was reviewed by IDT · All staff received in-serving on call light response time and meal set up. · Nursing staff were in-serviced on providing baths per resident preference, documentation of bathing and meal set up. · A performance improvement tool has been developed to monitor that ADL care *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly check (5) patients receive showers, meals are set up for mealtime, and have call lights answered timely. This Quality Assurance Audit Toll 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	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An Admission Minimum Data Set (MDS) assessment, dated 1/1/23, indicated an intact cognitive status, no behaviors, required extensive assistance of 2 for bed mobility and toileting, was dependent for transfers and bathing, and was incontinent of bowel and bladder. A Care Plan, dated 12/27/22, indicated assistance was required for ADLs. The interventions included the resident would be encouraged to use the call light for assistance and assistance would be provided for all ADLs. 3. During an observation on 2/17/23 at 12:20 p.m., Resident J was lying in bed. The head of the bed was up and she was leaning to the left side of the bed. The over the bed table was partially across the bed. The lunch tray was on top of the table and was uncovered. The resident was unable to reach the tray due to her position and the position of the table. Resident J said at the time of the observation, the table needed to be pulled closer to her. At 12:28 p.m., CNA 1 and CNA 2 entered the room. They indicated they had not delivered the meal tray to the resident. If they would have delivered the tray, they would have repositioned her so she was able to reach her food. They then assisted the resident with positioning and re-heated the food. On 2/17/23 at 12:39 p.m., the Activity Director indicated she had delivered the lunch tray at approximately 12:05 p.m. and placed it on the over the bed table. She indicated they were not to leave the plate covers in the room and she had "mentioned" to Nurse 1 the over the bed table needed adjusted. On 2/17/23 at 12:41 p.m., Nurse 1 indicated she had not been informed the resident needed to be		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;* 3/16/2023	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	repositioned. The bathing records indicated resident was to receive bathing on Tuesdays and Fridays. The bathing schedule indicated bathing was to be completed on Monday and Thursdays. The bathing records indicated bathing had not been completed on January 2 or 3, 2023, January 23 or 24, 2023, January 30 or 31, February 9 or 10, and February 13, or 14, 2023. Resident J's record was reviewed on 2/21/23 at 10:23 a.m. The diagnoses included, but were not limited to, cognitive communication deficit. A Quarterly MDS assessment, dated 12/27/22, indicated an intact cognitive status, no behaviors, required extensive assistance with bed mobility, dependent with transfers, supervision with eating, and was dependent for bathing. A Care Plan, dated 9/14/22, indicated an ADL deficit. The interventions included assistance would be provided for ADLs and meals would be set up and supervised. 4. Resident C's record was reviewed on 2/20/23 at 9:05 a.m. The diagnoses included, but were not limited to, peripheral vascular disease. A Quarterly MDS assessment, dated 1/22/23, indicated an intact cognitive status, required extensive assistance with bed mobility and transfers and was dependent for bathing. A Care Plan, dated 5/20/22, indicated she preferred bathing three times a week and as needed and a shower or bed bath would be completed three times a week.			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, dated 3/25/22, indicated assistance was required for ADLs. The interventions included assistance would be provided for ADLs. The bathing schedule indicated bathing was to be provided on Monday, Wednesday and Friday. The bathing record indicated bathing had not been completed on 1/13/23, 1/25/23, 1/27/23, 1/30/23, 2/1/23, 2/6/23, 2/10/23, 2/13/23, and 2/15/23. 5. Resident D's closed record was reviewed on 2/20/23 at 12:28 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly MDS assessment, dated 12/14/22, indicated a severely impaired cognitive status, no behaviors, required limited assistance with bed mobility, supervision with transfers, and was dependent on staff for bathing. A Care Plan, dated 9/2/22, indicated a deficit in self care for ADLs. The interventions indicated she was dependent on staff for bathing. The bathing schedule indicated bathing was scheduled for Tuesdays and Fridays. The bathing record indicated bathing had not occurred from January 4 through January 28, 2023 and had not occurred from January 29 through February 6, 2023. During an interview on 2/20/23 at 1:15 p.m., the Director of Nursing indicated she thinks the bathing was getting done, but the staff were not documenting the bathing. This Federal tag relates to Complaints IN00400504			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and IN00401479. 3.1-38(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 Physician ordered interventions were in place related to compression stockings for a resident with edema, for 1 of 8 residents reviewed for quality of care. (Resident C) Finding includes: Resident C was observed on 2/20/23 at 8:30 a.m., 10:24 a.m., and 11:18 a.m., dressed for the day and sitting on the side of the bed. Her legs were hanging down on the side of the bed and she was not wearing compression socks. During an interview on 2/20/23 at 11:18 a.m., Nurse 1 indicated the compression socks were not on the resident. Resident C's record was reviewed on 2/20/23 at 9:05 a.m. The diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease.	F 0684	F684 [D] Quality of Care It is the practice of this facility that we 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 developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Residents C had a compression stocking put on immediately in accordance with her physician order. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective*	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Order, dated 2/8/23, indicated a compression stocking was to be worn on the right leg when out of bed for swelling. A Nurse Practitioner's Progress Note, dated 2/7/23 at 12:13 p.m., indicated the resident stated she had some swelling and it was worse now. there was no pain, warmth, redness, or tenderness. She was instructed to elevate her legs when possible and compression stockings were to be utilized. The right lower extremity had swelling and she had peripheral vascular disease changes to the leg. she was to elevate the leg when in bed, be monitored for signs and symptoms of deep vein thrombosis, and compression stockings were to be used. This Federal tag relates to Complaint IN00400504. 3.1-37(a)		*action(s) will be taken;* · All residents who have orders for compression stockings have been reviewed by the DON to ensure physician orders are being followed. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* · In-servicing occurred with all nursing staff regarding receiving treatment and care in accordance with physicians orders. · A performance improvement tool has been developed to monitor that compression stockings are applied per physician order. *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 (5) residents to ensure compression stockings are applied as ordered. 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.	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			By what date the systemic changes will be made; 3/16/2023	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident's fall was thoroughly investigated for the root cause and circumstances of the fall to prevent further falls. The facility also failed to ensure residents who were at risk for falls had care-planned interventions in place, related to a floor mat next to the bed and non-skid strips applied to the floor for 3 of 3 residents reviewed for falls. (Residents C, G, and H) Findings include: 1. Resident C's record was reviewed on 2/20/23 at 9:05 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 1/22/23, indicated no cognition problems, required extensive assistance of two for bed mobility and transfers, no impairment of the upper or lower	F 0689	F689 [D] Free of Accident Hazards/ Supervision Devices It is the practice of this facility that resident falls are thoroughly investigated and appropriate interventions put in place on the care plan. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Residents C had a fall intervention added to the care plan based on information available in the chart. · Resident G floor mat was placed appropriately at bedside according to the plan of care · Nonskid strips were placed on the floor next to the bed of	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extremities, and had one fall without injuries. A Care Plan, dated 3/25/22, indicated a risk for falls and an actual fall occurred on 1/4/23. The interventions included, safety checks, therapy would screen for transfer status initiated on 4/26/22, staff would anticipate and meet the resident's needs, she would be encouraged to participate in activities to promote exercise, physical activity to improve mobility, and information on past falls would be reviewed to attempt to determine the cause of the falls initiated on 3/18/22. A Nurse's Progress Note, dated 1/4/23 at 9:29 a.m., indicated the resident was observed lying on the floor on her left side. A neurological and range of motion assessment was completed. There had been no complaints of pain and the vital signs were within normal ranges. The resident had been on the telephone with a family member when the fall occurred. The Nurse Practitioner was notified. The fall on 1/4/23 had not been investigated for the root cause of the fall and the circumstances of the fall. There were no interventions initiated to prevent further falls. During an interview on 2/20/23 at 1:15 p.m., the Director of Nursing (DON) indicated there was no investigation for the cause of the fall nor the circumstances of the fall. A fall and fall risk policy, dated 3/2018 and received from the Administrator as current, indicated the resident would be evaluated for specific risks and causes of a fall in an attempt to prevent the resident from a fall. 2. Resident G was observed on 2/21/23 at 8:39		Resident H. *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 fallen have the potential to be affected by the alleged deficiency. · All falls from the previous two months have been reviewed and have a root cause analysis with interventions in place · All residents who at risk for falls and have been reviewed by the IDT for Fall Risk Evaluation scores of 10 or above and provided interventions which address potential or actual root cause factors. Care plans have been updated. *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 procedures for falls was reviewed by IDT · An in-service was completed with all nursing staff regarding completing a root cause analysis of the fall, ensuring current care plan interventions are in place, and developing a new intervention based on the root cause of the falls. · A performance improvement tool has been developed to audit for investigation completion, new intervention for the fall and audit of current interventions.	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m. and 8:45 a.m., lying in bed. The head of the bed was elevated and the bed was in low position. There was no mat on the floor next to the bed. The DON indicated at 8:45 a.m., the mat was not next to the bed, then moved the floor mat from the right side of the bed by the door to the right side of the bed next to the window. Resident G's record was reviewed on 2/21/23 at 8:38 a.m. The diagnoses included, but were not limited to, a fractured pelvis and dementia. The admission date into the facility was 2/13/23 and an MDS assessment was not completed. A cognitive assessment was completed on 2/17/23 with a result of moderately impaired cognitive status. A Fall Risk Assessment, dated 2/16/23, indicated a high risk for falls. A Care Plan, dated 2/13/23, indicated a risk for falls. An intervention, initiated on 2/16/23, indicated a floor mat would be placed at the bedside and the staff were to ensure the mat was in place at all times. A Physician's Order, dated 2/17/23, indicated the resident was a fall risk and a floor mat was to be at the bedside. 3. Resident H was observed on 2/21/23 at 8:59 a.m. sitting in a wheelchair in her room. There were no non-skid strips on the floor next to her bed. On 2/21/23 at 10:11 a.m., the Administrator indicated there were no non-skid strips on the floor next to the bed.		*How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly check (5) patients to ensure residents and investigation was completed and fall interventions are in place. 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;* 3/16/2023	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident H's record was reviewed on 2/21/23 at 9:21 a.m. The diagnoses included, but were not limited to, stroke A Quarterly MDS assessment, dated 2/2/23, indicated a moderately impaired cognitive status, required supervision of bed mobility and transfers, balance was not steady without staff assistance, and had no falls. A Care Plan, dated 1/12/22, indicated a risk for falls. Interventions included, the resident's needs would be anticipated and met, the call light was to be in reach and she was to be encouraged to use the call light, appropriate footwear would be worn with ambulation or wheelchair mobilization. A Nurse's Progress Note, dated 11/30/22 at 9:46 p.m., indicated the resident was observed sitting on the floor on the side of the bed. She had indicated she had slipped out of bed when she attempted to go to the bathroom. The Interdisciplinary Team Progress Note, dated 12/1/22 at 10:38 a.m., indicated the intervention of non-skid strips next to the bed would be initiated and the Care Plan would be reviewed and updated. This Federal tag relates to Complaints IN00400504. 3.1-45(a)(2)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides-			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to serve 1 of 1 meals observed at an appetizing temperature as well as palatable foods and proper temperatures for other meals served, related to a lunch meal served with temperatures of the food under 135 degrees and not palatable to taste, for 1 of 1 discharged resident (Resident B) and 6 of 9 current residents interviewed for food service. (Residents C, E, N, P, Q, and R) Findings include: 1. Discharged Resident B was interviewed on 2/17/23 at 10 a.m. per telephone, and indicated the food was not palatable during the stay at the facility. They had served raw/undercooked biscuits, undercooked french fries, and the food was always served cold. 2. The following residents were interviewed on 2/17/23: At 9:10 a.m., Resident E indicated the food served did not taste good and was served cold. At 10:31 a.m., Resident N indicated the food served did not taste good. At 10:46 a.m., Resident C indicated the food served did not taste good and was served cold. At 11:11 a.m. , Resident R indicated the food served did not taste good and was served cold. The menu posted in outside of the Dining Room, indicated the lunch meal consisted of buttered	F 0804	F804 [E] Nutritive Value/Appear, Palatable/Prefer Temp It is the practice of this facility that we ensure that residents receive food prepared by methods that conserve nutritive value, flavor, appearance, palatable, attractive, and safe/appetizing temperature based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Residents E, N C, R, P, Q were interviewed to determine if taste and texture is to their liking. · Residents E, C and R were interviewed to determine temperature is to their liking. · Meals are prepared according to the recipe or manufacturers guidelines. · Resident B was discharged. *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 are served meals at the facility have the potential to be affected by the	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	crumb Tilapia, french fries, green beans, and vanilla pudding. The noon meal trays arrived to the first floor on 2/17/23 at 12:01 p.m. and a test tray was included with the residents trays. The sample meal was tested at 12:05 p.m., immediately after the residents received their meals. The Tilapia was observed with pink areas on the outer fillet. The temperature of the Tilapia fillet was 108 degrees. It was cold to taste and had a strong fish taste. The green beans had a temperature of 116.9 and were cold to taste, and the mashed potatoes served had a temperature of 128.3 and was tepid to taste. The Dietary Manager was interviewed at the time the lunch meal was tested and indicated the Tilapia was cooked to temperature and they were precooked fillets. Residents C, P, Q, and N were interviewed on 2/17/23 at 12:12 p.m. through 12/16 p.m.. They had all been served the Tilapia for lunch. Resident C, P, Q, and N indicated the Tilapia had not tasted good. Resident N indicated the french fries were too hard to eat. Cook 1 was interviewed on 2/17/23 at 12:44 p.m. and indicated she had been training another cook today. The Tilapia was raw and was not pre-cooked and the fillets were cooked to 140 degrees. She indicated she checked the temperature of all the fillets cooked except the smaller fillets and they all had the temperature of 147 degrees. She indicated they were served to the residents at 145 degrees. The Dietary Manager entered the kitchen during the interview and indicated she had been wrong about the Tilapia being pre-cooked and indicated the Tilapia was		alleged deficiency. · All residents food preferences were audited and updated · Facility added enclosed carts to meal pass and had an additional covered cart fixed to help with meal pass times *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 reviewed for serving of food was reviewed by the IDT · In-servicing was completed with the kitchen staff regarding food preparation and food temperatures · A performance improvement tool has been developed to audit resident satisfaction with food palatability and temperatures. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audt (5) residents at meals to assure they are in the correct temperature guidelines and prepared properly. This Quality Assurance Audit Tool will be completed by the Food Service Supervisor/ 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	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	raw before it was cooked. An Internet resource, titled https://eating expired.com, indicated raw Tilapia fillets would have a visible red blood lines or veins and the flesh would be pinkish white in color. The color of the fillet would change to completely white/opaque when fully cooked. An undated policy for serving food, received from the Administrator on 2/21/23 at 9:22 a.m. as current, indicated all hot food would be held during service at or above 135 degrees. All food items were to be served at a palatable temperature. This Federal tag relates to Complaints IN00399626, IN00400138, and IN00400247. 3.1-21(a)(2)		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;* 3/16/2023	
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			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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			

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the corrective actions taken by the facility. §483.80(e) Linens. 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 and interview, the facility failed to ensure infection control practices and standards were maintained related to medication administration for 2 of 4 residents observed during the medication administration observation. (Residents K and L) Findings include: 1. During a medication administration observation on 2/17/23 at 10:24 a.m., Nurse 1 was observed preparing Resident K's medications, which included 11 oral medications. She popped each of the medications out of their individual pill cards into her hand and then placed the medications in a medication cup one by one. She then administered the medications to the resident. 2. During a medication administration observation on 2/17/23 at 10:50 a.m., Nurse 1 was observed preparing Resident L's medications, which included 5 oral medications. She popped each of the medications out of their individual pill cards into her hand and then placed the medications in a medication cup one by one. She then administered the medications to the resident. Interview with the Director of Nursing (DON) on	F 0880	F880 [D] Infection Prevention and Control It is the practice of this facility that infection control practices and standards are maintained related to medication administration. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Residents K and L's primary physician was made aware of the alleged deficient practice. · 1:1 in-service occurred with Nurse 1 regarding proper infection control practices with medication administration *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 medication have the potential to be affected by the alleged deficiency. · All staff who administer medications were observed to	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/17/23 at 11:37 a.m., indicated the nurse should not have touched the pills with her hands. She would provide education to the nurse immediately. 3.1-18(a)		complete a medication pass to ensure that proper infection control practices were followed. No further alleged deficiencies were identified. *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 procedures for medication administration was reviewed by the IDT · An in-service was held with all staff that administer medications regarding medication administration and infection control. · A performance improvement tool has been developed to audit medication administration to ensure infection control practices are followed. *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 (5) medication passes to assure infection prevention is being followed properly. 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	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 3/16/2023	
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 sanitary and homelike environment, related to stained ceiling tiles, scraped walls, and a loose/hanging wall protector, for 4 of 12 rooms observed on 1 of 2 Units observed. (Rooms 102, 108, 116, and 127) Findings include: During the initial tour of the facility on 2/17/23 at 9:10 a.m. through 11:30 a.m. the following was observed: - At 9:10 a.m., there were water stained ceiling tiles in room 102. - At 10:26 a.m., there four water stained ceiling tiles in room 108. - At 10:46 a.m., the wall behind the head of the bed by the door in room 116 had a large amount of scrapes. - At 11:14 a.m., the wall behind the bed by the door in room 127 had a wall protector that was hanging off the wall and a large amount of scrapes on the wall. During an interview on 2/20/23 at 10:10 a.m., CNA 1 indicated Maintenance is notified if any repairs are needed.	F 0921	F921 [E] Safe/Functional/Sanitary/ Comfortable Environment It is the practice of this facility that the facility is maintained in a sanitary and homelike environment based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* · Room 102 and 108 ceiling tiles no longer have water marks. · Room 116 wall was repaired and painted. · Room 127 wall protector was fixed. *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. · All rooms were audited to ensure ceiling tiles had no water	03/16/2023

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This Federal tag relates to Complaint IN00400247. 3.1-19(f)		marks, and wall protectors were in place. If present, the findings were repaired or painted. · An outside contractor was hired to assist with painting/patching needing to occur in the facility. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* · 1:1 In-servicing occurred with maintenance director regarding needed repairs in the facility. · A performance improvement tool has been developed to audit ceiling tiles, condition of walls and wall protectors throughout the facility. *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 (5) rooms to ensure the identified items are in good repair. This Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee Weekly 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.	

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	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			By what date the systemic changes will be made: 3/16/2023	