PRINTED: 06/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	<u></u>	COMPL	ETED
		155289	B. W	ING		05/13/	2021
		100-00					
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					COLONIAL OAKS DR		
	AL OAKS HEALTH (				N, IN 46953		
(X4) ID		TATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 0	000	We at the facility are hereby		
		diana Department of Health			respectfully requesting this		
	in accordance with	-			agency consider paper		
					compliance/desk review for		
	Survey Date: 05/13	/21			compliance for the following pl	an	
	, 00/10				of correction as opposed to a		
	Facility Number: 00	0186			survey revisit. We are willing to		
	Provider Number: 1				submit any and all documenta		
	AIM Number: 1002				as requested to assure our		
	Allyl Nulliber. 1002	200300			credible compliance with the		
	At this Emangement I	Duran and durang summary			deficiencies noted in the follow	ina	
		Preparedness survey,			CMS-2567. We are hereby	ilig	
		th Care Center was found not			<u>-</u>		
	-	Emergency Preparedness			providing our plan of correction	1.	
	-	ledicare and Medicaid			Submission of this Plan of		
		ers and Suppliers, 42 CFR			correction does not constitute		
		has a capacity of 127 and			admission or an agreement by	the	
	had a census of 91 a	t the time of this survey.			provider of the truth of facts		
					alleged or corrections set forth		
	Quality Review con	npleted on 05/17/21			the statement of deficiencies.		
					Plan of Correction is provided		
					evidence of the facilities desire	e to	
					comply with regulations and		
					continue to provide quality care	e.	
					Please accept this Plan of		
					Correction as our credible		
					allegation of compliance.		
E 0039	403.748(d)(2), 416	5.54(d)(2), 418.113(d)(2),					
SS=F	441.184(d)(2), 482	2.15(d)(2), 483.475(d)(2),					
Bldg	483.73(d)(2), 484.	102(d)(2), 485.625(d)(2),					
-	. , , ,	727(d)(2), 485.920(d)(2),					
	. , , ,	1.12(d)(2), 494.62(d)(2)					
	EP Testing Requir						
		18.113(d)(2), §441.184(d)					
	(2), §460.84(d)(2),						
	. ,	33.475(d)(2), §484.102(d)					
	(2), §485.68(d)(2),						
	(=), g 100.00(d)(2),	3.00.020(4)(2),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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

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TITLE

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	CON	TE SURVEY  MPLETED  13/2021
	PROVIDER OR SUPPLIER AL OAKS HEALTH		4725 S	ADDRESS, CITY, STATE, ZIP CO COLONIAL OAKS DR N, IN 46953	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	§485.727(d)(2), §4 (2), §494.62(d)(2).	185.920(d)(2), §491.12(d)				
	OPO, "Organization CMHCs at §485.9 §491.12, and ESF	6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at &D Facilities at §494.62]:				
	exercises to test the	acility] must conduct ne emergency plan ility] must do all of the				
	community-based (A) When a commot accessible, cofunctional exercise (B) If the [facinatural or man-marequires activation the [facility] is exenext required com	nunity-based exercise is nduct a facility-based e every 2 years; or lity] experiences an actual ade emergency that of the emergency plan, mpt from engaging in its munity-based or individual, tional exercise following				
	(ii) Conduct an adevery 2 years, opportulescale or function paragraph (d)(2)(i) conducted, that molimited to the follow (A) A second fullescommunity-based functional exercises (B) A mock disaste (C) A tabletop exelled by a facilitator discussion using a clinically-relevant	ditional exercise at least posite the year the ponal exercise under of this section is ay include, but is not wing: scale exercise that is or individual, facility-based exercise or workshop that is and includes a group				

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Event ID:

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	IENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY  IPLETED  13/2021
	F PROVIDER OR SUPPLIE		4725 S	ADDRESS, CITY, STATE, ZIP COD COLONIAL OAKS DR DN, IN 46953	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	to challenge an et (iii) Analyze the [fi maintain document exercises, and en the [facility's] emet *[For Hospices at (2) Testing for hothe patient's home conduct exercises at least annually. following:  (i) Participate in a community based (A) When a community based (A) When a community based functional (B) If the hospice man-made emergactivation of the eis exempt from er full scale community following the onse (ii) Conduct an advers, opposite the functional exercis of this section is conclude, but is not (A) A second full-community-based functional exercis (B) A mock disass (C) A tabletop exeled by a facilitator discussion using a clinically-relevant a set of problem secretals.	acility's] response to and natation of all drills, tabletop nergency events, and revise argency plan, as needed.  418.113(d):] spices that provide care in e. The hospice must is to test the emergency plan. The hospice must do the a full-scale exercise that is every 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires mergency plan, the hospital agaging in its next required nity-based exercise or based functional exercise of the emergency event. Editional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION		SURVEY LETED 5/2021
	PROVIDER OR SUPPLIER		4725 S	ADDRESS, CITY, STATE, ZIP COE COLONIAL OAKS DR ON, IN 46953	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) mergency plan.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	(3) Testing for hos care directly. The exercises to test the per year. The hos (i) Participate in a exercise that is co (A) When a commot accessible, co facility-based function of the enhospice is exempting activation of the enhospice is exempting activation of the enhospice is exempting activation of the enhospice is exempting the onset of the endit of the end of the	spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale mmunity-based; or munity-based exercise is induct an annual individual stional exercise; or experiences a natural or ency that requires mergency plan, the is from engaging in its next community based or stional exercise following mergency event. diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared				
	*[For PRFTs at §4 §482.15(d), CAHs	41.184(d), Hospitals at at §485.625(d):]				

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	OF CORRECTION	IDENTIFICATION NUMBER:  155289	ICATION NUMBER:  A. BUILDING		COMPLETED 05/13/2021	
	PROVIDER OR SUPPLIER		4725 S	ADDRESS, CITY, STATE, ZIP CODE COLONIAL OAKS DR ON, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	conduct exercises twice per year. The must do the follow (i) Participate in a exercise that is co (A) When a common accessible, confacility-based function (B) If the [PRTF, Fexperiences an accemergency that recommunity based functional exercise emergency event. (ii) Conduct a exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A mon (C) A tabletop is led by a facilitated discussion, using a clinically-relevant a set of problem since the follow (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded.  *[For PACE at §46 (2) Testing. The Pace in a community to the pace in the facine in the facine in the facine in the face in the fac	mannual full-scale mmunity-based; or unity-based exercise is induct an annual individual, tional exercise; or lospital, CAH] tual natural or man-made quires activation of the ine [facility] is exempt from it required full-scale or individual, facility-based or following the onset of the in [additional] annual it may include, but is not ving: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed ored questions designed inergency plan. ine [facility's] response to mentation of all drills, in, and emergency events iility's] emergency plan, as				

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	<del></del>	COMPI	
		155289	B. W	'ING		05/13	/2021
		- -	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		4725 S	COLONIAL OAKS DR		
COLONIA	AL OAKS HEALTH	CARE CENTER			N, IN 46953		
(V4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID			(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
TAG	1	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		<u> </u>		TAG	DEFICIENC!)		DATE
	1	The PACE organization					
	must do the follow	_					
		an annual full-scale					
		ommunity-based; or					
	1 ' '	nunity-based exercise is					
		onduct an annual individual,					
	1	ctional exercise; or					
	1 ' '	xperiences an actual					
		ade emergency that n of the emergency plan,					
		npt from engaging in its next					
		community based or					
	•	based functional exercise					
	1	et of the emergency event.					
		an additional exercise every					
		the year the full-scale or					
	1	e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited to	_					
		-scale exercise that is					
		or individual, a facility					
	based functional						
	(B) A mock disas						
	l ` '	ercise or workshop that is					
		and includes a group					
	discussion, using	<del>-</del> -					
	'	emergency scenario, and					
		statements, directed					
	messages, or pre	pared questions designed					
	to challenge an er						
	ı	PACE's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	_	ity] must conduct exercises					
	l ' ' -	ency plan at least twice per					
	_	announced staff drills					
	•	ncy procedures. The [LTC					
	l -	· •					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO			NSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	<del></del>	COMPL	
		155289	B. W	ING		05/13/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				4725 S	COLONIAL OAKS DR		
COLONIA	AL OAKS HEALTH	CARE CENTER		MARIO	N, IN 46953		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ust do the following:					
		an annual full-scale					
		ommunity-based; or					
	1 ' '	nunity-based exercise is					
		onduct an annual individual,					
	facility-based fund						
	_ ' ' -	ility] facility experiences					
		or man-made emergency					
		ration of the emergency					
	I	lity is exempt from					
	•••	required a full-scale or individual, facility-based					
	· ·	e following the onset of the					
	emergency event.	_					
	1 -	dditional annual exercise					
	1 ' '	but is not limited to the					
	following:	bat to flot illfillion to the					
		scale exercise that is					
	1 ' '	or an individual, facility					
	based functional e	•					
	(B) A mock disas						
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	· ·	emergency scenario, and					
	•	statements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	5 71					
		LTC facility] facility's					
		naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	\$483 475(d)]·					
		CF/IID must conduct					
	1 ' '	he emergency plan at least					
		ie ICF/IID must do the					
	following:						
	•	n annual full-scale exercise					
	`						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE COMPL 05/13/	ETED
	PROVIDER OR SUPPLIER			4725 S (	DDRESS, CITY, STATE, ZIP CODE COLONIAL OAKS DR N, IN 46953	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	not accessible, co facility-based function (B) If the ICF/IID is natural or man-marequires activation the ICF/IID is exernext required full-sindividual, facility-following the onse (ii) Conduct an additional that may include, following:  (A) A second full-scommunity-based facility-based function (B) A mock disaste (C) A tabletop exelled by a facilitator discussion, using clinically-relevant a set of problem is messages, or presto challenge an erection (iii) Analyze the IC maintain documer exercises, and emitted ICF/IID's emeritation (IID) is emeritational to the ICF/IID's emeritation (IID) in the exercises to test the least annually. The following:  (i) Participate in a community-based (A) When a cois not accessible, in a cois not accessible, in a cois in the ICE in the	unity-based exercise is induct an annual individual, itional exercise; or. experiences an actual ide emergency that of the emergency plan, inpt from engaging in its ideale community-based or cased functional exercise it of the emergency event. Iditional annual exercise out is not limited to the ideale exercise that is or an individual, itional exercise; or ideal exercise; or ideal exercise; or ideal exercise, and includes a group ideal exercise or ideal exercise ideal exercise is ideal exercise.  F/IID's response to and ideal exercise ideal exerci					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 8/2021
	PROVIDER OR SUPPLIER AL OAKS HEALTH		4725 S	ADDRESS, CITY, STATE, ZIP COI COLONIAL OAKS DR N, IN 46953	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	natural or man-mare requires activation the HHA is exemply required full-scale individual, facility of following the onse (ii) Conduct an adyears, opposite the functional exercise of this section is conclude, but is not (A) A second community-based facility-based functional exercise of this section is conficult of the functional exercise facility-based functional facility functional facility functional	limited to the following: full-scale exercise that is or an individual, tional exercise; or saster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed bared questions designed energency plan. HA's response to and station of all drills, tabletop ergency events, and revise ency plan, as needed.  36.360] e OPO must conduct the emergency plan. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
ANDILAN	or connection	155289	B. WING	<del></del>	05/13/2021
		100209	_		03/13/2021
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP CODE	
COLONIA	AL OAKS HEALTH	CARE CENTER		S COLONIAL OAKS DR DN, IN 46953	
COLOINIA	AL OAKS HEALTH	CARE CENTER	IVIAINIC	, IN 40933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		f the OPO experiences an			
		nan-made emergency that n of the emergency plan,			
		ot from engaging in its next			
		xercise following the onset			
	of the emergency	_			
		PO's response to and			
	• •	ntation of all tabletop			
		nergency events, and revise			
		OPO's] emergency plan,			
	as needed.	3 31 7			
	*[ RNCHIs at §403	3.748]:			
	(d)(2) Testing. The	e RNHCI must conduct			
	exercises to test the	he emergency plan. The			
	RNHCI must do th	•			
		er-based, tabletop exercise			
		A tabletop exercise is a			
		led by a facilitator, using a			
		r-relevant emergency			
		et of problem statements,			
		s, or prepared questions			
	-	enge an emergency plan.			
		NHCI's response to and ntation of all tabletop			
		nergency events, and revise rgency plan, as needed.			
		view and interview, the	E 0039	No residents experienced adv	erse 06/01/2021
		nduct exercises to test the	E 0039	reactions to this deficient	00/01/2021
		east twice per year, including		practice. All residents residing	in
		drills using the emergency		the facility have the potential t	
		C facility must do the		affected by this deficient pract	I
	following:	-		The Administrator will complete	
	-	annual full-scale exercise		Covid-19 actual event	
	that is community-b			documentation for one of the	
	a. When a commun	ity-based exercise is not		exercise requirements. A live,	
		an annual individual,		community tornado drill was	
	facility-based funct			conducted at the facility on	
		y experiences an actual		3/16/2021. The exercises will	be
	natural or man-mad	le emergency that requires		documented in facility's	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	l` ′	JILDING	NSTRUCTION	(X3) DATE COMPL 05/13/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	4725 S	ODDRESS, CITY, STATE, ZIP CODE COLONIAL OAKS DR N, IN 46953	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	facility is exempt fr required full-scale is individual, facility-lexercise for 1 year factual event.  (ii) Conduct an additional exercise.  (ii) Conduct an additional exercise.  (ii) Conduct an additional exercise.  (iii) Anock disaster of the conductional exercise.  (iii) A mock disaster of the conductional exercise.  (iii) An alyze the LT maintain documental exercises, and emer LTC facility's emergaceordance with 42 deficient practice of the conductional exercises.  (iii) Analyze the LT maintain documental exercises, and emer LTC facility's emergaceordance with 42 deficient practice of the conduction of the facility is using event as one of the documentation regal emergency plan in recovidad emergency plan in recovidad exercise of choice the community-based exercise of choice the community-based exercise for th	drill; or se or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan.  C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.			Emergency Preparedness Manual. Any concerns noted receive immediate follow-up Administrator/designee reports be presented at monthly QA review and plan of action will adjusted accordingly.	rt will for	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/13/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000	available for review Based on interview the Maintenance Di stated the facility is COVID emergency but documentation second exercise of o with in the last year The findings were r	at the time of records review, rector and the Administrator using the current natural as one of the requirements, was not completed, and a choice was not conducted			
Bldg. 01	Licensure Survey w Department of Heal CFR 483.90(a).  Survey Date: 05/13  Facility Number: 00 Provider Number: 1000  At this Life Safety 0 Health Care Center with Requirements Medicare/Medicaid Life Safety from Fit the National Fire Pr 101, Life Safety Co Existing Health Car 16.2.  This one story facility	00186 155289 266300 Code survey, Colonial Oaks was found not in complance	K 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following pof correction as opposed to a survey revisit. We are willing to submit any and all documents as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction Submission of this Plan of correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement of deficiencies. Plan of Correction is provided evidence of the facilities desir comply with regulations and continue to provide quality can	post to ation  wing on. an y the h on The l as e to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155289		(X2) MULTII A. BUILDI B. WING		nstruction 01	(X3) DATE : COMPL 05/13/	ETED		
NAME OF PROVIDER OR SUPPLIER  COLONIAL OAKS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0222 SS=E	with smoke detection open to the corridor detectors in the residual capacity of 127 and time of this survey.  All areas where the access were sprinkle facility services was used for the storage  Quality Review control NFPA 101  Egress Doors	cility has a fire alarm system in in the corridors, areas is and hard wired smoke dent rooms. The facility has d had a census of 91 at the residents have customary ered. All areas providing is sprinklered, except a garage of maintenance supplies.			Please accept this Plan of Correction as our credible allegation of compliance.			
Bldg. 01	not be equipped we requires the use of egress side unless special locking arr. CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one loce permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times.  18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the	king arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155289		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2021			
NAME OF PROVIDER OR SUPPLIER  COLONIAL OAKS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  4725 S COLONIAL OAKS DR  MARION, IN 46953				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both the systems are arrand upon activation.  18.2.2.2.5.2, 19.2. DELAYED-EGRETARRANGEMENTA Approved, listed do systems installed 7.2.1.6.1 shall be assemblies servin contents in building an approved, superdetection system automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRANA Access-Controlled installed in accordate be permitted.  18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRANA Elevator lobby existing accordance with 7 on door assemblies throughout by an automatic fire detection automatic fire detection system.  18.2.2.2.4, 19.2.2.	elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system.  2.4  OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall  2.4  BY EXIT ACCESS NGEMENTS I access door locking in 1.2.1.6.3 shall be permitted approved, supervised approved, supervised approved, supervised action system and an seed automatic sprinkler	K 0222	No residents experienced adv	erse 06/01/2021		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED			
155289		B. W	ING		05/13/2	2021		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
					COLONIAL OAKS DR			
COLONIA	AL OAKS HEALTH	CARE CENTER		MARION, IN 46953				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
		6 delayed egress locking			reactions to this deficient			
		installed in accordance with			practice. Residents on Chestn	ut I		
	-	nich states an irreversible			Hall and Walnut Grove have the			
		e the lock in the direction of			potential to be affected by this			
	_	conds, or 30 seconds where			deficient practice. Both deficie			
	_				doors have been repaired with			
		hority having jurisdiction,			•			
		a force to the release device			new alarms and keypads. The			
	_	0 under all of the following			Maintenance Supervisor/desig			
	conditions:				will complete observations of t			
		not be required to exceed 15			egress doors three times a we			
	lbf (67 N).				for four weeks, then two times			
	(b) The force shall not be required to be				week for four weeks, then wee	, ,		
	continuously applied for more than 3 seconds.				thereafter. The observations w	/III		
	(c) The initiation of the release process shall				be documented on the TELS			
	activate an audible signal in the vicinity of the				Preventative Maintenance Log			
	door opening.				Any concerns noted will receiv			
	(d) Once the lock has been released by the				immediate follow-up. Monitorir	ng		
	application of force to the releasing device,				will continue until substantial			
	_	y manual means only. This			compliance is achieved as			
	-	ould affect 35 residents in			determined by the Quality			
	the Walnut Grove hall and Chestnut hall				Assurance committee. After			
					consecutive compliance is			
	Findings include:				achieved, the Maintenance			
					Supervisor/designee will rando	omly		
	Based on observation	on during a tour of the facility			complete the observation to			
	with the Maintenance Director and Administrator				ascertain continued compliand	e at		
	on 05/13/21 at 11:0	0 a.m. and 11:30 a.m., the			lease biannually. The			
	Walnut Grove hall a	and Chestnut hall exit doors			Maintenance Supervisor/desig	nee		
	were equipped with	a 15 second delayed egress.			report of monitoring will be			
	When the exit doors	s were tested the irreversible			forwarded to the Administrator	for		
	process to release th	ne lock was not initiated.			monthly QA review and the pla	an of		
		at the time of observation,			action will be adjusted			
	the Maintenance Di	rector tried 4 times to			accordingly.			
	activate the delay eg	gress and stated the delayed						
	egress is not workin	g and will need to be						
	repaired.							
	_							
	The findings were r	eviewed with the Maintenance						
		ministrator during the exit						
	conference.							
			1		İ	Į.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED	
155289		B. WING	<u> </u>	05/13/2021	
	PROVIDER OR SUPPLIER		4725 S	ADDRESS, CITY, STATE, ZIP CODE COLONIAL OAKS DR N, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a ponly used for compatient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care roother UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the pinstalled and meet 10.2.3.6 (NFPA 98 400-8 (NFPA 70), 12-5 Based on observation	ent - Power Cords and ent - Power Strips and electrical equipment es that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE e UL 60601-1. Power strips the patient care rooms in meet UL 1363. In coms, power strips meet es. All power strips are precautions. Extension d as a substitute for fixed e. Extension cords used moved immediately upon courpose for which it was es the conditions of 10.2.4. ent of the cords were not for fixed wiring	K 0920	Extension cord was removed f beauty shop immediately upor finding. No residents experience	1
	NFPA-70/2011, 400 permitted in 400.7 f shall not be used for	0.8 state unless specifically lexible cords and cables (1) as a substitute for fixed int practice could affect up to		adverse reactions related to the deficient practice. All residents residing in the facility have the potential to be affected by this deficient practice. The facility	is s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 01		COMPLETED			
155289			B. Wl	B. WING			/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					COLONIAL OAKS DR			
COLONI	AL OAKS HEALTH	I CARE CENTER			N, IN 46953			
					1			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					staff was reeducated on the			
	Findings include:				facility policy for Use of Electri			
					Power Strips or Surge Protect			
		ion during a tour of the facility			The facility policy and procedu			
		nce Director and Administrator			for Guidelines for Use of Elect			
		40 p.m., hair clippers and a			Power Strips or Surge Protect			
		ugged into and supplied power			was reviewed with no change:	s		
	by an extension co	ord in the Beauty Shop. Based		indicated. The Maintenance				
	on interview at the	e time of observation, the		Supervisor/designee will complete				
	Maintenance Dire	ctor and Administrator			random room observations			
	acknowledged an extension cord was in use and				weekly. The observations will be			
	remove the extension cord.				documented on the TELS			
					Preventative Maintenance Log	g.		
	The finding was re	eviewed with the Maintenance			Any concerns noted will receive	/e		
	Director and the A	Administrator during the exit			immediate follow-up. Monitorii	ng		
	conference.				will continue until substantial			
					compliance is achieved as			
	3.1-19(b)				determined by the Quality			
	l , , ,				Assurance committee. After			
					consecutive compliance is			
					achieved, the Maintenance			
					Supervisor/designee will rand	omly		
					complete the observation to	,		
					ascertain continued compliance	ce at		
					lease biannually. The			
					Maintenance Supervisor repo	rt of		
					monitoring will be forwarded to			
					Administrator for monthly QA			
					review and the plan of action	will		
					be adjusted accordingly.			
					a sajastoa asooranigiy.			

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