PRINTED: 10/13/2022
FORM APPROVED

CENTERS FOI	ENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		r í	JILDING	ONSTRUCTION 01	(X3) DATE COMPI 09/07		
	PROVIDER OR SUPPLIEF			119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisafety Code Recert Survey conducted by Health on 06/06/22 483.90(a). Survey Date: 09/07 Facility Number: 09/07 Facility Number: 100 At this Life Safety of Home was found not Requirements for Phedicare/Medicaid Life Safety from Finational Fire Protectife Safety Code (In Health Care Occupation of Was built at three disbuilding was constructed in 1986 fully sprinklered and detection located in spaces open to the corooms. Battery open located in some of the survey of the s	isit was conducted on the Life ification and State Licensure by the Indiana Department of in accordance with 42 CFR 7/2022 00360 155733 290370 Code survey, Colonial Nursing of in compliance with	K 0	000			
	dually certified for	certified beds. All 55 beds are Medicare and Medicaid. At ey, the census was 35.					

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING B. WING	01		LETED 1/2022
	ROVIDER OR SUPPLIER AL NURSING HOME		119 N II	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
		residents have customary aviding facility services were appleted on 09/13/22				
K 0161 SS=F Bldg. 01	NFPA 101 Building Construct Building Construct 2012 EXISTING Building constructi Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5 Construct I (442), I of stories sprinklered II (111) non-sprinklered II (211) sprinklered III (211) sprinklered V (111) III (200) non-sprinklered V (000) sprinklered Sprinklered Sprinklered Sprinklered	ion Type and Height ion Type and Height on type and stories meets less otherwise permitted by 9.1.6.7				

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STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	LETED
		155733	B. W	ING		09/07/2022	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			NDIANA AVE		
COLONI	AL NURSING HOM	F			N POINT, IN 46307		
OOLOIVII	TE NORGING HOW			OROW	141 01141; 114 40007		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG	Ì	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	9.7. (See 19.3.5)						
		iption, in REMARKS, of the					
	construction, the number of stories, including basements, floors on which patients are						
	located, location of smoke or fire barriers and						
	dates of approval. Complete sketch or attach						
	small floor plan of the building as appropriate. Based on interview and record review, the facility was not an acceptable type of construction as						
			K 0	161	K225 Stairways and		02/15/2023
					Smokeproof Enclosures		
		101 - 2012 edition, Sections			What corrective action(s) will be		
	· ·	NFPA 220 - 2012 edition,			accomplished for those reside	nts	
	Section 4.1, 4.1.1 and Table 4.1.1. This deficient				found to have been affected b	У	
	practice could affect	et all 35 residents.			the deficient practice?		
					Requesting compliance with		
	Findings include:				alleged deficiency through the	Life	
					Safety Equivalency granted		
		view with the Interim			through the FSES once all		
		Maintenance Director on			required work in the FSES is		
		a.m. to 12:30 p.m., the facility			complete and a passing score		
		be Type V(000) construction as			achieved. These stairs would	only	
		otected wood structure and			be used in an emergency		
		vo stories. Type V (000) is not			situation, i.e. fire evacuation a	nd	
		of construction for a two-story			do reach the sidewalk downst		
	_	building. Based on record			for egress to outside the build	-	
		ty's plan of correction, the			An independent company, RT		
		apgrade the fire alarm system			completed an FSES review in		
	-	order to achieve a passing			2021 and determined all the		
		conducted on 06/29/22. Based			Interstitial spaces of the		
		h the Interim Administrator at			basement levels and 2nd floor		
		eview, the facility had not			require the installation of smol	ke	
	completed the fire a	alarm system upgrades.			and heat detectors. Once the		
					smoke detection system is		
	_	viewed with the Interim			installed, it will give these zone		
	Administrator at the	e exit conference at 11.49 a.m.			passing FSES score, including		
					the stairwell. Installation has b	een	
		s cited on 06/06/22. The facility			delayed by plan review and		
	_	a systemic plan of correction			SafeCare obtaining the neces	-	
	to prevent recurrence	ce.			equipment to complete the sm	ioke	
					detection system.		
	3.1-19(b)				Based on FSES scoring,		

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155733	B. WING		09/07/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	COMPLETION		
TAG	ì ·	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				additional work will need to be done to upgrade the smoke detection system. Total Cover smoke detection includes the installation of automatic smoke detection in all rooms, halls, storage areas, basementattics, lofts, spaces above suspended ceilings, and other subdivisions and accessible spaces as well as the inside oclosets, elevator shafts, enclostairways, dumb waiter shafts chutes (NFPA 72-2010 Section 17.5.3.1). The facility hired the company SafeCare, to designate areas requiring additional smoke detection coverage. They will upgrade the Fire Alarm System SafeCare will submit the necessary paperwork to the Indiana State Department of Health and Homeland Security the design release. There are changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan review not be necessary per Amy Kelat Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire paradditional smoke and heat detectors, carbon monoxide detectors, strobes, pull station and relay modules with a	rage rage fall sed and n also m. y for no y will lley of the nel,	

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completion date of December 5,

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION 2022. Once the install has been completed Life safety will be notified to give certification of completed engineer plans. A new FSES survey was conducted on 6/29/22 by RTM, completed paperwork included. SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. The project is estimated to start in October of 2022 pending the availability of parts. The facility is		I OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
COLONIAL NURSING HOME (X4) ID REFIX (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC IDENTIFYING INFORMATION) TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC IDENTIFY ACTION SHOULDED COMPLETED DATE. TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ACTION SHOULDED COMPLETED COMPL	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING		COMPLETED	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION TAG SUMMARY STATEMENT OF DEFICIENCY TAG DEPTITED SHOULD BE THE APPROPRIANTE DEFILITION TAG 2022. Once the install has been completed Life safety will be notified to give certification of completed engineer plans. A new FSES survey was conducted on 6/29/22 by RTM, completed paperwork included. SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. The project is estimated to start in Octobor 2022 pending the availability of parts. The facility is				119 N	INDIANA AVE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG	COLONIAL NURSING HOME		CROV	VN POINT, IN 46307		
completed Life safety will be notified to give certification of completed engineer plans. A new FSES survey was conducted on 6/29/22 by RTM, completed paperwork included. SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. The project is 3-4 weeks. The project is setimated to start in October of 2022 pending the availability of parts. The facility is	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vendor. We have also contacted Koorsen Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 weeks. The project is estimated to start in October of 2022 pending the availability of parts. The facility is					completed Life safety will be notified to give certification of completed engineer plans. A new FSES survey was conducted on 6/29/22 by RTM	, ,
the Complete Smoke Detection System described above to be performed by SafeCare. This will give the building a passing score in the FSES. Milestones					SafeCare has attempted to ord the necessary parts to complete the project but the parts are backordered. Colonial is attempting to get a list of the needed parts from SafeCare to see if the needed parts can be obtained from a different vende We have also contacted Koors Fire Co. to see if they would be able to complete the project sooner, which they could not (response included). No definite start date can be given at this time. They estimated time to complete the project is 3-4 were The project is estimated to start in October of 2022 pending the availability of parts. The facility committed to the installation of the Complete Smoke Detection System described above to be performed by SafeCare. This we give the building a passing scot in the FSES.	der te or or. sen e te te vis f n or

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representative/designee will communicate with vendor Safe Care at minimum 2 times per month for updates and

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CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BI		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE COMPI	(X3) DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIEF		119 N	T ADDRESS, CITY, STATE, ZIP COD I INDIANA AVE WN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
				developments r/t pending p Colonial Nursing representative/designee wil update of status to ISDH of pending project monthly by 15th of each month and with new development until project complete. Reporting will be writing by email and referent Survey ID. ISDH will be notified in writi email when parts are receive Vendor to complete project. Notified when project begin when project is complete. How the facility will identify residents having the potent be affected by the same de practice and what corrective will be taken? Potentially 6 residents on the upper floor could be affecte above remedies cover all postairways and smokeproof enclosures. What measures will be put place or what systematic che the facility will make to ensu deficient practice does not in The Maintenance Director v educated on the proper FSI paperwork for the Life Safe binder. How the corrective action(s monitored to ensure the dei practice will not recur, i.e., v quality assurance program	the h each ect is in nice and to ficient e action end. The otential into manges are the recur? will be ES ty will be ficient what	

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put into place?

Proper FSES paperwork will be reviewed in QAPI meeting on at

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI		SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155733	B. WI	B. WING			09/07/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	L		119 N I	NDIANA AVE			
COLONIA	AL NURSING HOM	E		CROWN POINT, IN 46307				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					least a quarterly basis.			
					By what date the systemic			
					changes will be completed? 2/15/23			
					2/15/23	ļ		
K 0225 NFPA 101								
SS=E		okeproof Enclosures						
Bldg. 01	,	•						
3	Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used							
	as exits are in accordance with 7.2.							
	18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2							
	Based on observation and interview, the facility			225	K225 Stairways and		02/15/2023	
	failed to provide and maintain exit stairs and exit				Smokeproof Enclosures			
	stair enclosures in accordance with NFPA 101 -				What corrective action(s) will	ll be		
	2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2,				accomplished for those			
	7.1.3.2.1, 7.1.3.2.3, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1,				residents found to have been	n		
	7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2,				affected by the deficient			
					practice?			
		.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2						
		1 (b). This deficient practice			Requesting compliance with			
	could affect approx	imately 6 of the 35 residents.			alleged deficiency through to			
					Life Safety Equivalency gran	ited		
	Findings include:				through the FSES once all			
	Based on observation				required work in the FSES is			
		Maintenance Director on			complete and a passing sco			
		our of the facility from 9:30 a.m.			achieved. These stairs would only be used in an emergence			
	_	ollowing was discovered:			situation, i.e. fire evacuation	-		
	· ·	oom 201 was not enclosed in			and do reach the sidewalk			
	·	on. The door to the stair did			downstairs for egress to out	side		
	not have fire resista				the building.			
		201 consisted of metal open						
		ces. The landing and all of the			An independent company,			
	-	etal open grate where there was			RTM, completed an FSES			
	1/4-inch piece of me	etal and a 1-inch gap between			review in 2021 and determin	ed		
	-	pieces. This building is a			all the Interstitial spaces of t	he		
	healthcare occupand	•			basement levels and 2nd flo	or		
		201 continued down from the			will require the installation o	f		
		sers to the bottom of the stair			smoke and heat detectors. C)nce		
	without an intermitt	ent landing. The			the smoke detection system	is		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/07/2022
	ROVIDER OR SUPPLIER		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307	
(X4) ID PREFIX TAG	approximately 15-for allowable maximum landings. d) the stair by room width and not the rewidth. Based on record revice correction, the facilialarm system prior to a passing score on to 06/29/22. Based on Administrator at the had not completed to This finding was read Administrator at the Administrator at the This deficiency was	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Dot distance exceeded the in 12-foot distance between 201 only had a 30-inch clear required minimum 36-inch clear riew of the facility's plan of ity planned to upgrade the fire to 09/05/22 in order to achieve the FSES conducted on in an interview with the Interim the time of interview, the facility the fire alarm system upgrades. Wiewed with the Interim the exit conference at 11.50 a.m. The cited on 06/06/22. The facility a systemic plan of correction the cited on 06/06/22 in the facility and the cited on 06/06/22 in the facility of the cited on 06/06/22 in the facility and the cited on 06/06/22 in the facility of the cited on 06/06/22 in the facility of the cited on 06/06/22 in the cited on 06/06/22	ID PREFIX TAG	installed, it will give these zero a passing FSES score, including the stairwell. Installation has been delayer plan review and SafeCare obtaining the necessary equipment to complete the smoke detection system. Based on FSES scoring, additional work will need to done to upgrade the smoke detection includes the installation of automatic smoke detection in all room halls, storage areas, baseme attics, lofts, spaces above suspended ceilings, and oth subdivisions and accessible spaces as well as the inside all closets, elevator shafts, enclosed stairways, dumb we shafts and chutes (NFPA 72 Section 17.5.3.1).	be ins, ents, ere e of
				The facility hired the compa SafeCare, to designate area requiring additional smoke detection coverage. They we also upgrade the Fire Alarm System. SafeCare will subm the necessary paperwork to Indiana State Department of Health and Homeland Secur for the design release. There	it the ity

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>01</u> B. WING			ETED	
		155733	B. W				/2022	
	PROVIDER OR SUPPLIER		_ !	119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					no changes to NFPA 99 or the facility's essential electrical system. Based on information from the engineer, plan reviewill not be necessary per An Kelley at Indiana State Department of Health (emails attached). SafeCare will install/replace the following items: a new fire panel, additional smoke and heat detectors, carbon monoxide detectors, strobes, pull stational relay modules with a completion date of December 2022. Once the install has be completed Life safety will be notified to give certification completed engineer plans.	on ew ny s ons er 5, een		
					A new FSES survey was conducted on 6/29/22 by RTI completed paperwork included SafeCare has attempted to order the necessary parts to complete the project but the parts are backordered. Color is attempting to get a list of the needed parts from SafeCare see if the needed parts can be obtained from a different vendor. We have also contact Koorsen Fire Co. to see if the	nial the to be		

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would be able to complete the project sooner, which they

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	Γ OF HEALTH AND HU R MEDICARE & MEDIO					RM APPROVED IB NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPI 09/07	SURVEY LETED
	PROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE 'N POINT, IN 46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORM	K LSC IDENTIFYING INFORMATION	IAG	could not (response include No definite start date can be given at this time. They estimated time to complete project is 3-4 weeks. The project is estimated to start in October of 2022 per the availability of parts. The facility is committed to the installation of the Complete Smoke Detection System described above to be performed by SafeCare. Thi will give the building a pass score in the FSES. Milestones	the oding	DATE	
				Colonial nursing representative/designee will communicate with vendor S Care at minimum 2 times pe month for updates and developments r/t pending project. Colonial Nursing representative/designee will report update of status to IS of pending project monthly the 15th of each month and	afe er I GDH by	

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with each new development until project is complete. Reporting will be in writing by email and reference Survey ID.

ISDH will be notified in writing by email when parts are received by Vendor to

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 09/07/2022		
	ROVIDER OR SUPPLIE		119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				complete project. Notified when project begins and whe project is complete.	n
				How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	е
				Potentially 6 residents on the upper floor could be affected The above remedies cover all potential stairways and smokeproof enclosures.	
				What measures will be put in place or what systematic changes the facility will make ensure the deficient practice does not recur?	
				The Maintenance Director wi be educated on the proper FSES paperwork for the Life Safety binder.	
				How the corrective action(s) will be monitored to ensure the deficient practice will not rective, what quality assurance program will be put into place	he ur,
				Proper FSES paperwork will reviewed in QAPI meeting on least a quarterly basis.	
				By what date the systemic changes will be completed?	

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/07/2022
	PROVIDER OR SUPPLIER		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 0353	NFPA 101			2/15/23	
SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkler	supply source RKS information on non-required or partial or system.			
	failed to ensure the throughout the facil indicated in the plar practice could affect in therapy. Findings include: Based on interview Interim Administrat Director at 12:14 p.	and NFPA 25 riew and interview, the facility ceiling construction ity was maintained as n of correction. This deficient t at least 6 residents and staff and record review with the for and the Maintenance m. on 09/07/22, the facility was becumentation of a facility wide	K 0353	K353 Sprinkler Systemmaintenance and testing What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? The residents and staff in the identified area were not harmed the alleged deficient practice. 2 areas identified by the surve were patched by the Director of Maintenance using 5/8 drywall give the area 1 hour protection	nts y ed by The yor of I to

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EPARTMENT OF HEALTH AND HUMAN SERVICES					
ENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMI		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE S		
AND DE LIVED CODD DOMESTIC	TD F1 (MYP) 0 - MY 01 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		COLEN		

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	CATION NUMBER A. BUILDING D1 B. WING O5		(X3) DATE SURVEY COMPLETED 09/07/2022
	PROVIDER OR SUPPLIE		1191	ET ADDRESS, CITY, STATE, ZIP COD N INDIANA AVE IWN POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF DEFICIENCIAL DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE COMPLETION
TAG	audit of the sprink surrounding them correction. This finding was re Administrator and the exit conference. This deficiency was	as cited on 06/06/22. The facility at a systemic plan of correction	TAG	create a smooth continuous ceiling. This has been visualized and CMS life safety survey 9/7/22 How the facility will identify residents having the potential be affected by the same of practice and what corrective will be taken? No other residents were as by the alleged deficient profacility wide audit of sprink heads and the ceiling surrethem was completed by the Maintenance Director to eath there was a smooth, continuous ceiling. No other were found. What measures will be purplace or what systematic of the facility will make to endeficient practice does not an in-service was done with the facility will make to endeficient practice does not an in-service was done with the facility will make to endeficient practice does not an in-service was done with the facility will make to endeficient practice does not an in-service was done with the facility will make to endeficient practice does not an in-service was done with the facility will make to endeficient practice does not a monitor the ceil surrounding sprinklers. Contracted vendor complete facility wide audit on 9/27/1 reviewed findings with maintenance director and administrator. Sprinkler he were cleaned and service indicated. How the corrective actions monitored to ensure the difference will not recur, i.e., quality assurance program.	by ISDH yor on iy other ntial to deficient ive action ffected actice. A der counding ne msure er areas it into changes sure the t recur? ith the nd a pol was ling eted a f22 and eads d as (s) will be deficient t, what

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	OF HEALTH AND HU						TED: RM APP B NO. 09	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	1 /	JILDING	onstruction 01	(X3) DATE : COMPL 09/07/	ETED	<i>r</i>
	ROVIDER OR SUPPLIE AL NURSING HOM			119 N II	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMP	(X5) PLETION ATE
					put into place? The Director of Maintenance of Designee will conduct an audi 5 random sprinkler heads in the building to ensure that the surrounding ceiling meets NFF guidelines of a smooth continusurface. The audit will be conducted weekly times 4 the monthly times five. This audit been added to the TELS systems.	PA Luous n has		

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NFPA 101

Portable Fire Extinguishers

Portable Fire Extinguishers

Portable fire extinguishers are selected, installed, inspected, and maintained in

K 0355

SS=E

Bldg. 01

Event ID:

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will be ongoing.

10/7/22

By what date the systemic changes will be completed?

for ongoing monitoring. The facility will conduct and document monthly audits of sprinkler heads and the ceiling around the sprinkler heads to ensure the sprinkler system operates as designed and sprinkler response time is not inhibited by holes or gaps. Ongoing, the administrator or designee will monitor the

ceiling/sprinkler system to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/07/2022 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on interview and record review, the facility K 0355 K355 Portable Fire 10/07/2022 failed to ensure portable fire extinguishers were **Extinguishers** properly maintained in accordance with NFPA 10, What corrective action(s) will be Standard for Portable Fire Extinguishers. This accomplished for those residents deficient practice could affect 6 residents and staff found to have been affected by on the second floor the deficient practice? The residents and staff in the Findings include: identified area were not harmed by the alleged deficient practice. The Based on interview and record review of the "2022 fire extinguisher in the wall recess Life Safety Audits" with the Interim Administrator was attached to the wall using a and the Maintenance Director at 12:14 p.m. on mounting bracket. 09/07/22, the facility was unable to provide a This has been visualized by ISDH monthly audit for August to ensure the and CMS life safety surveyor on compliance of five fire extinguishers in the 9/7/22 and state fire marshal on building as indicated in the plan of correction. 9/13/22 with no deficit findings. How the facility will identify other This finding was reviewed with the Interim residents having the potential to Administrator and the Maintenance Director at be affected by the same deficient the exit conference at 12.25 p.m. practice and what corrective action will be taken? This deficiency was cited on 06/06/22. The facility No other residents were affected failed to implement a systemic plan of correction by the alleged deficient practice. A to prevent recurrence. facility wide audit of fire extinguishers was completed by 3.1-19(b)the Maintenance Director to ensure that all were properly stored according to NFPA guidelines. No unsecure fire extinguishers were found. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur? An in-service was done with the Director of Maintenance on the proper securing of fire

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X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY	
A. BUILDING 01 COMPLETED	
B. WING 09/07/2022	
A. BUILDING <u>01</u> COMPLETED	
	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) extinguishers according to NFPA guidelines. An audit tool will be created to ensure that the fire extinguishers are properly secured according to NFPA guidelines. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility will conduct and document monthly audits of fire extinguishers to ensure the fire extinguishers operate as designed and immediately available for use. Ongoing, the administrator or designee will monitor portable fire extinguishers to ensure continued compliance. Results of the review will be reviewed during the facility Quality Assurance meeting; monitoring will be ongoing. The audit tool will be completed by the Director of Maintenance or designee weekly times four then monthly times five to ensure that 5 random fire extinguishers in the building are being properly stored. This information will be reviewed in

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NFPA 101

Corridor - Doors

K 0363

SS=E

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	l ,	ILDING	NSTRUCTION 01	(X3) DATE COMPL 09/07/	ETED
	ROVIDER OR SUPPLIER AL NURSING HOM			119 N IN	DDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mate- hardware. Roller is CMS regulation. T apply to auxiliary s flammable or com Clearance betwee covering is not exi doors complying v if provided with a of the door closed w applied. There is closing of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies.	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are led protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,					
		ngs automatics closing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155733	B. WING		09/07/2022	
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		INDIANA AVE		
COLONIA	AL NURSING HOM	E		N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	devices, etc.					
		on and interview, the facility	K 0363	K363 Corridor-Doors	10/07/2022	
		f over 5 corridor doors in the		What corrective action(s) will be		
		npediment to closing and		accomplished for those reside		
	_	or frame. This deficient		found to have been affected b	у	
	practice could affect	et 6 residents in the Therapy		the deficient practice?		
	room.			The residents and staff in the		
				identified area were not harme	=	
	Findings include:			the alleged deficient practice.		
				areas identified by the surveyo	· ·	
		ons with the Interim		therapy room, social service a	nd	
		the Maintenance Director on		administrator office were		
		6 p.m. to 12:20 p.m., the		immediately corrected, and do	oors	
		doors in the basement were		were closed.		
	propped open with			How the facility will identify oth		
	1. the Therapy Roo			residents having the potential		
	2. the Administrato	or office		be affected by the same defici		
	3. The Social			practice and what corrective a	ction	
		ns/Activities/Maintenance		will be taken?		
	Director's office			No other residents were affect		
	Based on interview			by the alleged deficient practic		
		Iaintenance Director agreed		All residents have the potentia		
		corridor doors were propped		be affected. An audit of corrid	lor	
	_	wasn't aware the doors were		doors was complete and any		
	not allowed to be pr	ropped open.		impediment to door closure wa	as	
	TT1 : 0: -:			corrected.		
	I -	cknowledged by the Interim		What measures will be put into		
		the Maintenance Director at		place or what systematic char	-	
	the exit conference	at 12:25 p.m.		the facility will make to ensure		
	21.100			deficient practice does not rec		
	3.1-19(b)			An in-service was done with the		
				Director of Maintenance on do		
				closures and proper maintena		
				to prevent impediment to corri	aor	
				door closure. Doors were		
				inspected for proper functioning	_	
				and staff were educated to util		
				and monitor proper door closu		
l				and not prop doors open with	any	

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device.

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPL 09/07/	ETED
	PROVIDER OR SUPPLIEI		119 N	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				How the corrective action(s) we monitored to ensure the deficiency practice will not recur, i.e., who quality assurance program will put into place? The Director of Maintenance of Designee will conduct an audit 3 random corridor doors in the building to ensure that doors a closed or opened properly. The audit will be conducted weekly times 4 then monthly times five This information will be review the QA meeting at least quarter By what date the systemic changes will be completed? 10/7/2022	ent at I be or t of ane ee.	
K 0522 SS=D Bldg. 01	heating plant, is discombustible mater device, and has a and shut down equivers excessive temper fuel fired, the device is chimney or vertakes air for commore provides for a confrom occupied are 19.5.2.2	ing Device ie, other than a central esigned and installed so rials cannot be ignited by safety feature to stop fuel uipment if there is ature or ignition failure. If ice also: int connected. inbustion from outside. industion system separate is a atmosphere.				
		and record review, the facility f 1 laundry rooms maintained	K 0522	K522 HVAC- Any Heating		10/07/2022

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the intake combustion air from the outside for the

create an atmosphere rich with carbon monoxide

which could cause physical problems for all staff

fuel fired dryers. This deficient practice could

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What corrective action(s) will be

found to have been affected by

the deficient practice?

accomplished for those residents

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l i		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155733	B. W	B. WING		09/07/	2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	L			NDIANA AVE			
COLONIA	AL NURSING HOM	E			N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	in the laundry room				No residents were identified a	S		
	F: 1: : 1 1				being harmed by the alleged			
	Findings include:				deficient practice. The piece of	rt .		
	D 1 '4 '	1 1 : 64 #2022			cardboard was immediately			
		and record review of the "2022			removed while the surveyor w			
	1	with the Interim Administrator			present allowing fresh air intal			
		e Director at 12:14 p.m. on			into the dryer room from outsi			
	i ·	y was unable to provide a			This has been visualized by the			
	monthly audit for A	~			ISDH and CMS life safety sur	veyor		
	1 -	ntake combustion air for the indicated in the plan of			on 9/7/22			
	correction.	indicated in the plan of			How the facility will identify of			
	correction.				residents having the potential			
	This finding was no	viewed with the Interim			be affected by the same defici			
		he Maintenance Director at			practice and what corrective a	Ction		
					will be taken?	łod		
	the exit conference	at 12.23 p.m.			No other residents were affect			
	This deficiency was	s cited on 06/06/22. The facility			by the alleged deficient practic			
	1	a systemic plan of correction			This is the only laundry area in	ııne		
	to prevent recurrence	•			facility. No other areas in the building required checking.			
	to prevent recurrent	Se.			What measures will be put into	^		
	3.1-19(b)				place or what systematic char			
	3.1-17(0)				the facility will make to ensure	-		
					deficient practice does not red			
					An in-service was done with the			
					Director of Maintenance and			
					laundry staff on the proper			
					ventilation and dangers of blo	ckina		
					air intakes. An audit tool was	9		
					created to ensure that this are	a is		
					monitored and not obstructed			
					preventing fresh air intake.			
					How the corrective action(s) w	ill be		
					monitored to ensure the defici			
					practice will not recur, i.e., wh			
					quality assurance program wil			
					put into place?			
					The facility will conduct and			
					document monthly audits of fr	esh		
					air intakes in the laundry room			

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i '		r ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER 155733		A. BUILDING <u>01</u> B. WING		COMPLETED 09/07/2022		
		.557.55	2. ,,1		DDDEGG GITW GT FT TIP COP	00/01/		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD NDIANA AVE			
COLONIA	AL NURSING HOM	E			N POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
					with gas-fired dryers to ensure intakes remain clear. Ongoing administrator or designee will monitor these areas to ensure for combustion is taken from outside to ensure continued compliance. Results of the monitoring will be reviewed duthe facility's Quality Assurance meeting; monitoring will be ongoing and this task has bee added to the TELS system. The audit tool will be complete the Director of Maintenance or designee weekly times four the monthly times five to ensure the air intake in the laundry are not obstructed allowing for proair intake. This information will reviewed in the QA meeting at least quarterly. By what date the systemic changes will be completed? 10/7/2022	, the air ring e n ed by ren nat ea is per l be		
K 0712 SS=F	NFPA 101 Fire Drills							
Bldg. 01		he transmission of a fire simulation of emergency fire						
	and unexpected ti							
	The staff is familia	t quarterly on each shift. r with procedures and is						
		re part of established						
	9:00 PM and 6:00	ills are conducted between AM a coded						
		av be used instead of						

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/07/2022 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility K 0712 **K712 Fire Drills** 10/07/2022 failed to ensure 1 of 1 August fire drills included What corrective action(s) will be the verification of transmission of the fire alarm accomplished for those residents signal to the monitoring station in fire drills found to have been affected by conducted between 6:00 a.m. and 9:00 p.m. for the the deficient practice? last 4 quarters. LSC 19.7.1.4 requires fire drills in All residents could potentially be health care occupancies shall include the harmed by the alleged deficient transmission of a fire alarm signal and simulation practice. A fire drill will be of emergency fire conditions. This deficient conducted during the day shift on practice affects all residents in the facility as well 6/24/22. All proper steps will be as staff and visitors. followed and the monitoring company will notified of the drill. Findings include: Complete How the facility will identify other Based on record review of titled "Fire Drill Report" residents having the potential to with the Interim Administrator and the be affected by the same deficient Maintenance Director on 09/07/22 at 10:59 a.m. practice and what corrective action the fire drill conducted on 08/31/22 didn't include will be taken? transmission of the fire alarm signal. Based on All residents could potentially be interview at the time of record review, the affected by the alleged deficient Maintenance Director confirmed that the practice. An audit of the drill transmission of alarm did not occur on the conducted on 6/24/22 will done to aforementioned fire drills. ensure that proper protocol was followed and the monitoring This finding was reviewed with the Administrator company was notified. complete and Maintenance Director at the exit conference at What measures will be put into 12.25 p.m. place or what systematic changes the facility will make to ensure the This deficiency was cited on 06/06/22. The facility deficient practice does not recur? failed to implement a systemic plan of correction An in-service was done with the to prevent recurrence. Director of Maintenance on the proper fire drill and notification 3.1-19(b) procedures. An audit tool was 3.1-51(c)created to ensure that all fire drills are conducted properly. This tool

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is also added to TELS for continued monitoring. Additional education was provided to

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10/13/2022 PRINTED:

	FOF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039	
STATEMEN	TOF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	A. BUILDING <u>01</u> CO			(X3) DATE COMPL	DATE SURVEY COMPLETED 09/07/2022	
	PROVIDER OR SUPPLIEF			119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307			
(X4) ID PREFIX TAG	(4) ID SUMMARY STATEMENT OF DEFICIENCIE REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Maintenance director to ensure drills are pushed to service for proper notification on all shifts required intervals. How the corrective action(s) we monitored to ensure the deficite practice will not recur, i.e., which is a pushed to program will put into place? The facility will conduct and document monthly audits of the fire drills to ensure drills included.	e fire at ill be ent at be	(X5) COMPLETION DATE	
					documentation of the transmis of the alarm signal. Ongoing, t administrator or designee will monitor fire drills to ensure the documentation is complete. Results of the monitoring will be reviewed during the facility Qu Assurance meeting; monitoring ongoing and has been added the TELS system The audit tool will be complete the Director of Maintenance or	he pe ality g to		
					designee monthly times six to ensure that all fire drills that m were properly conducted, and monitoring company was notifilf there are any errors identifie another drill will be conducted ensure proper procedures are followed. This information will reviewed in the QA meeting at least quarterly. By what date the systemic	onth the ied. d to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DQE222

Facility ID: 000360

10/7/22

changes will be completed?

If continuation sheet

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