	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	î ´	ILDING NG	ONSTRUCTION 00	(X3) DATE COMPL 12/16/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN 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)	ATE	(X5) COMPLETION DATE
F 0000 Bldg. 00 F 0684 SS=E	IN00395293 and IN Complaint IN00395 Federal/State deficit allegations are cited Complaint IN00396 Federal/State deficit allegations are cited allegations are cited Survey dates: Deceroid Deceroid In Inc. Survey dates: Deceroid Inc. Facility number: 1002 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type Medicare: 3 Medicaid: 23 Other: 5 Total: 31	reflect State Findings cited in O IAC 16.2-3.1.	F 00	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect January 8, 2023. We respectfire request paper compliance for survey resolution.	fic fic serve s or cility	
Bldg. 00	§ 483.25 Quality of Quality of care is a	of care a fundamental principle that ment and care provided to					

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

TITLE (X6) DATE

Jennifer Short Administrator 01/06/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155733	B. WI	NG		12/16	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	S.			NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
(X4) ID	STIMMADV	STATEMENT OF DEFICIENCIE	1	ID	1		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	facility residents. E			1110			DATE
	,	sessment of a resident, the					
		re that residents receive					
		e in accordance with					
	professional standards of practice, the						
	comprehensive person-centered care plan,						
	and the residents'	-					
			F 06	584	F684 [E] Quality of Care		01/08/2023
	Based on record rev	view and interview, the facility			It is the practice of Colonial		31.00.2025
	failed to provide tre	-			Nursing and Rehab that reside	ents	
	accordance with professional standards of				receive treatment and care in		
	practice and the comprehensive care plan, related				accordance with professional		
	to lack of an assessment of pain prior to the				standards of practice, the		
	administration of pain medications by a Licensed				comprehensive person-center	ed	
	Nurse and an assess	ement of the effectiveness of			care plan, and the residents'		
	the pain medication	after the the administration,			choices.		
	for 4 of 5 residents	reviewed for a risk for pain care			What corrective action(s) will I	be	
	plan. (Residents D,	E, F, and G) The facility also			accomplished for those reside		
	failed to administer	pain medications as ordered			found to have been affected b	y	
	for resident D.				the deficient practice;		
					Residents D, E, F, G physicial	ns	
	Findings include:				were notified of assessments	not	
					being completed prior to the		
		ord was reviewed on 12/16/22			administration of pain medicat	tion	
	at 9:39 a.m. The dia	ignoses included, but were not			and the assessing of effective	ness	
	limited to, dementia	and spinal stenosis.			after the administration of		
					medication. The physician for		
		um Data Set (MDS)			resident D was also notified of	f	
		1/10/22, indicated a severely			pain medication not being		
		frequent pain was present,			administered as ordered.		
		opioid pain medication daily			How other resident having the		
	the past seven days.				potential to be affected by the		
					same deficient practice will be	•	
	· ·	4/11/18, indicated chronic pain			identified and what corrective		1
	_	terventions included, the pain			action(s) will be taken;		
		e administered as ordered, the			All residents that are ordered		
		notified if pain medications			routine and/or PRN pain		
		ere not effective, and pain			medication have the potential	to	
	assessment would b	e completed as needed.			be affected by the deficient		
1	I		ı		practice Audits were conducted	ed	1

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155733	B. W	ING		12/16/	/2022
		L	<u> </u>	CTD FET	ADDRESS CITY STATE 7IB COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
COLONII	AL NILIDONO LION	4E			NDIANA AVE		
COLONIA	AL NURSING HOM	IC		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Order, dated 11/3/22, indicated			on the orders and medication		
		pain medication) 5-325			administration records of thos	e	
		ne tablet was to be given every			residents on pain medications	s to	
	12 hours for chroni	ic pain.			ensure pain assessments we		
					place prior to administration a		
		dministration Record (MAR),			monitoring of effectiveness of		
		icated the Percocet had been			medication. All medication red		
		.m. and 8 p.m. The Controlled			were also audited to ensure p	ain	
	_	Orug Record indicated the Percocet had been			medication was being		
	administered 9 a.m. and 5 p.m. on November 26,				administered as ordered.		
	27, 28, 29, and 30, 2022				What measures will be put int		
					place and what systemic char	nges	
	The MAR, dated 12/2022, indicated the Percocet				will be made to ensure that th	е	
		ered at 8 a.m. and 8 p.m. The			deficient practice does not red	cur;	
	_	ecord, indicated the Percocet			The policy for medication		
		ered at 9 a.m. and 5 p.m. on			administration was reviewed l	ру	
	December 1 -9, 202	22.			the IDT team. An in-service w	as	
					conducted with the licensed		
	_	w on 12/16/22 at 11:31 a.m., the			nurses and QMA's on pain		
		g (DON) indicated the Percocet			assessment by the nurse prio		
	had not been given	every 12 hours as ordered.			administration of pain medica	tion,	
					effectiveness monitoring and		
		order, dated 11/3/22, indicated			administering medications as		
		, one tablet could be given			ordered. A Performance		
		needed (prn) for chronic pain, in			Improvement Tool has been		
	addition to the ever	ry 12 hour pain medication.			developed that audits		
					assessments of pain prior to a		
		ug Record, indicated a prn			after medication administratio		
		n on 12/12/22 at 5 a.m., 12/15/22			and accurate administration o	f	
	1 -	ocet administration had not			pain medication .		
	been documented of						
		cord(MAR), dated 12/2022.			How the corrective actions wi		
		assessment of the pain prior to			monitored to ensure the defic	ient	
		of the medications and no			practice does not recur;		
		effectiveness of the pain			A performance improvement		
	medication.				has been initiated that randon	nly	
		0/0000 1 11 1 1			checks three (3) residents to		
		2/2022 indicated a prn Percocet			ensure that they are being		
		on 12/13/22 at 2:23 p.m. for pain.			assessed for pain prior to afte		
	There had been no	pain assessment or	1		administering pain medicatior	١,	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155733	B. W	ING	_	12/16/	/2022
NAME OF T	DROMDER OF CURPLYEE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		119 N II	NDIANA AVE		
	AL NURSING HOM	E	T	CROW	N POINT, IN 46307		
(X4) ID		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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	completed by a Lice	pain medication assessment			checking that it is reflected in controlled drug record and MA	D	
	completed by a Lice	elised Nuise.			and that medication is being	NT.	
	There were no pain	assessments documented in			administered as ordered. This		
	_	s Notes indicating why the prn			Quality Assurance Audit Tool		
	Percocet had been administered.				be completed by the Director		
					Nursing/ Designee Weekly for		
	2. Resident E's record was reviewed on 12/16/22				(4) weeks; then monthly for fiv	` '	
	at 9:10 a.m. The diagnoses included, but were not				months. In the event any furth		
	limited to, osteoarth	nritis.			concerns are identified the iss		
	A Quarterly MDS o	assessment, dated 9/24/22,			will be immediately corrected a additional training will be initia		
		cognitive status, no pain was			Results of the audit will be	ieu.	
	present, and no opioids had been administered in				reviewed at the Quality Assura	ance	
	the past seven days.				Meeting at least quarterly.		
		10/12/17, indicated acute pain			By what date the systemic		
	_	arthritis. The interventions			changes will be made: Januar	y 8,	
	_	ication as ordered by the			2023		
		administered and the pain interventions would be					
	observed.	pain interventions would be					
	-	r, dated 8/22/22, indicated					
	· ·	pain medication) 50 mg was to					
		ery six hours as needed for					
	pain (prn).						
	The Controlled Dru	g Record indicated the					
		n on 11/23/22 at 2 p.m. and 8					
	_	p.m. and 9 p.m., 11/28/22 at 2					
		d 11/29/22 at 8 p.m. There was					
		on the MAR, dated 11/2022,					
		ramadol had been given. An					
	_	ain and effectiveness of the d not been completed by a					
	Licensed Nurse.	a not been completed by a					
	Licensed Nuise.						
	The Controlled Dru	g Record indicated the					
	Tramadol was given	n on 11/27/22 at 8 a.m. The					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	î ´	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/16/	ETED
	PROVIDER OR SUPPLIEF			119 N IN	DDRESS, 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 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
	documented on the	egible. The Tramadol was not MAR and an assessment of weness of the pain medication eted.					
	Progress Notes an a pre-authorization w	nentation in the Nurses' assessment of the pain, as given, and the Tramadol November 23, 24, 28, and 29,					
	Tramadol had been p.m. and 8 p.m., 12 12/9/22 at 3:30 p.m p.m. and 9 p.m. and documentation on tindicating the Tram had been no assessing the transport of the	g Record indicated the administered on 12/1/22 at 2 /5/22 at 8 p.m., 12/6/22 at 2 p.m., and 9:30 p.m., 12/13/22 at 3 12/15/22 at 8 p.m. there was no he MAR, dated 12/2022, adol had been given. There ment of the pain or the pain medication completed by					
	Tramadol had been The MAR indicated given. There was no	g Record indicated the administered 12/12/22 at 8 a.m. If the medication had been assessment of the pain and pain medication completed by					
	pain or rationale for	mented assessments of the administration of the rses' Progress Notes.					
		ord was reviewed on 12/16/22 iagnoses included, but were not nritis.					
	indicated a moderat	elssessment, dated 11/8/22, tely impaired cognitive status, and had not received an					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/16/2022	
	PROVIDER OR SUPPLIER		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 Even days.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION
	chronic pain was pr indicated the effecti interventions would A Physician's Order hydrocodone (narco	the evaluated. c, dated 3/20/22, indicated on the pain medications) 5-325 y six hours for pain could be			
	hydrocodone had not have the Controlled Dru hydrocodone had be at 3 p.m. and 8 p.m. 11/29/22 at 7 p.m., were no assessment	pain medications completed			
	hydrocodone had be 7:11 p.m. The pain effectiveness of the Licensed Nurse. The Controlled Dru hydrocodone had be	g Record indicated the een administered the			
	at 3 p.m. and 8 p.m. administration had a MAR, dated 12/202 assessments and eff medication assessm 4. Resident G's reco	/22 at 2 p.m., and 8 p.m., 12/4/22, 12/14/22 at 3 and 9 p.m. The not been documented on the 2. There were no pain ectiveness of the pain ents by a Licensed Nurse. ord was reviewed on 12/16/22 tagnoses included, but were not			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/16/2022	
	ROVIDER OR SUPPLIEF		119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION al vascular disease and stroke.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	An Annual MDS as indicated an intact of received an opioid of days. A Care Plan, dated The interventions in would be administed A Physician's Order Norco (narcotic pair	sessment, dated 12/9/22, cognition, had no pain, and every day in the past seven 2/18/29, indicated chronic pain. accluded, the pain medications			
	was signed out on 1 p.m., 12/2/22, 12/3 at 2 p.m. and 10 p.m. 12/10/22 at 10 p.m. p.m. There was no dated 12/2022, the There had been no p	g Record indicated the Norco 2/1/22 at 11 p.m., 12/2/22 at 7 /22 at 2 p.m. and 10 p.m., 12/4/22 n., 12/8/22 at 1:30 a.m., 12/9/22, , 12/13/22, and 12/15/22 at 8:30 documentation on the MAR, Norco had been administered. pain assessments and effectiveness by a Licensed			
	been given on 12/12 2:35 p.m. There had	2/2022, indicated the Norco had 2/22 at 2:36 p.m. and 12/24/22 at d been no assessment of the less of the pain medication by a			
		•			
		on 12/16/22 at 10:13 a.m., LPN d been no Licensed Nurse the as needed pain			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155733	B. WI	NG		12/16/	2022
	ROVIDER OR SUPPLIER			119 N II	DDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	medications for Res	idents F and G.					
	Director of Nursing documentation and and the lack of pain An undated pain mathe Director of Nurscurrent, indicated if administered, documentation Management Function also be completeffectiveness of the	on 12/16/22 at 10:43 a.m. the acknowledge the missing assessments on the MARs assessments. anagement policy, provided by sing on 12/16/22 at 12 p.m. as a PRN pain medication was mentation was required on the Flow Sheet and documentation eted on the MAR. The medication was to be minutes after the medication					
F 0732 SS=C Bldg. 00	was given. A facility medicatio received from the D indicated documents the MAR immediate PRN medications w reason, and follow to This Federal tag relations and the Sederal tag relations and tag relations and the Sederal tag relations and the Sederal tag relations and tag re	on administration policy, pirector of Nursing as current, ation was to be completed on ely after the administration. Here to have the date, time, up results documented. ates to Complaint IN00396866.					
	must post the follo basis: (i) Facility name. (ii) The current dat (iii) The total numb worked by the follo licensed and unlice	owing information on a daily					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/16/2022			
	ROVIDER OR SUPPLIER AL NURSING HOM		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 APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
IAG	(A) Registered number (B) Licensed practive vocational nurses law). (C) Certified nurses (iv) Resident censive states (iv) Post (iv) The facility must data specified in proceed section on a daily each shift. (ii) Data must be proceed (B) In a prominent residents and visit staffing data. The written request, may available to the put to exceed the composted daily nurse minimum of 18 modes as required for all libuilding. This had the residents who reside findings include: 1, During an observation of the proceed states (in) the proceed	tical nurses or licensed (as defined under State a aides. us. Iting requirements. It post the nurse staffing paragraph (g)(1) of this basis at the beginning of posted as follows: Itable format. It place readily accessible to posted as follows: Itable format. It place readily accessible to posted nurse facility must, upon oral or take nurse staffing data public for review at a cost not immunity standard. It place readily accessible to posted nurse facility must, upon oral or take nurse staffing data public for review at a cost not immunity standard. It place readily accessible to posted nurse facility must, upon oral or take nurse staffing data public for review at a cost not immunity standard. It place readily accessible to posted nurse facility must, upon oral or take nurse staffing data posted acceptation and interview, the facility povide accurate staffing posts posted accurate staffing posts posted staff working in the potential to affect all of the	F 0732	F732 [C] Posted Nurse Staffir Information It is the practice of Colonial Nursing and Rehab to post ar provide accurate staffing post required for all licensed staff working in the building What corrective action(s) will accomplished for those reside found to have been affected by	ng 01/08/2023 nd s as be ents
	·	2/9/22, 12/12/22, and 12/13/22.		the deficient practice; Accurate nursing schedule po	

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	PROVIDER OR SUPPLIEF		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307	•
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
		esponsible for scheduling		was posted immediately and	
	indicated on 12/15/2	22 at 11:11 a.m., she had just		reflected proper information	
	posted the correct dates for the daily nursing			How other resident having the	e
	schedules. She had not worked 12/14/22 and no			potential to be affected by the	•
	one had posted the	hours over the past weekend.		same deficient practice will be	e
				identified and what corrective	,
	_	nedules from 11/1/22 through		action(s) will be taken;	
	11/13/22 and 12/1/2	22 through 12/15/22 were		All residents have the potenti	al to
	reviewed on 12/15/2	22 at 2:30 p.m		be affected by the deficient	
				practice. The nursing schedu	le will
	On 11/6/22, there w	as a Day Shift Nurse who had		be posted each day and upda	ated
	not shown for work	as scheduled and a Day and		each shift as changes in staff	ing
	Evening Shift CNA	Evening Shift CNA who had called in sick. The		occur.	
	Daily Nursing Staffing Post had not been updated			What measures will be put in	to
	with the changes.			place and what systemic cha	nges
				will be made to ensure that th	ne
	On 11/9/22, a Day S	Shift CNA had called off. The		deficient practice does not re	cur;
	Daily Nursing Staff	ing Post had not been updated		The protocol for the posting of	of
	with the changes.			nursing staffing has been rev	iewed
				by the IDT team. An in-service	e
	On 11/13/22, a QM	A was scheduled for the Day		was conducted with licensed	
	Shift and was not li	sted on the Daily Nursing		nurses on information require	ed for
	Staffing Post.			posting and updating prior to	each
				shift as scheduling changes	
		Shift CNA and Evening Shift		occur. A performance	
		The Daily Nursing Staffing		improvement tool has been	
	Post had not been u	pdated with the changes.		developed that audits complia	ance
				with posting and updating the)
		ning Shift CNA had called off.		schedule each shift	
	,	Staffing Post had not been		How the corrective actions w	ill be
	updated with the ch	anges.		monitored to ensure the defic	cient
				practice does not recur;	
		ning Shift CNA had called off		A performance improvement	
		e Night Shift CNA's scheduled.		has been initiated that will be	
		Staffing Post was not posted		review the daily posting of the	
	with the correct hou	ırs.		nursing schedule to ensure the	nat
				the information is accurate. T	his
		Shift CNA had called off. The		Quality Assurance Audit Toll	will
	Daily Nursing Staff	ing post was not updated with		be completed by the Director	of
	the change.		1	Nursing/ Designee Weekly fo	r four

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		onstruction 00	(X3) DATE COMPL 12/16/	ETED			
	ROVIDER OR SUPPLIER			119 N II	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	Administrator acknown not updated with ch	on 12/16/22 at 12:58 p.m., the owledged the postings were anges. ates to Complaint IN00395293.			(4) weeks; then monthly for five months. In the event any further concerns are identified the issue will be immediately corrected a additional training will be initial. Results of the audit will be reviewed at the Quality Assurated Meeting at least quarterly. By what date the systemic changes will be made: January 2023	er ue and ed.	
F 9999							
Bldg. 00	including alcoholic concentrates, and the beas ordered by the shall be supervised follows: (8) Per required need administered only unlicensed nurse or phonurse or physician reauthorization to administered in the retime and date of the This State rule was Based on record reversalled to ensure a Liansessed the resident	on of drugs and treatments, beverages, nutrition erapeutic supplements, shall attending physician and by a licensed nurse as d (PRN) medications may be pon authorization of a sysician. All contacts with a section the premises for minister PRNs shall be nursing notes indicating the	F 99	999	F9999 [3.1-25] Pharmacy Services It is the practice of Colonial Nursing and Rehab that a Licensed Nurse will be notified assess the resident, and pre-authorize as needed (PRN pain medication administered to QMA's. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice; Residents D, E, F, G physician were notified of the licensed no not supervising PRN medication being distributed by QMA 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 PRN pain medications have the	by ee nts / ns urse ons	01/08/2023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155733	B. W	NG		12/16/	/2022
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE 7IB COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD NDIANA AVE		
COLONIA	AL NURSING HOM	E			N POINT, IN 46307		
COLONIA	AL NURSING HUM			CROW	N FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ninistered by QMA's for 4 of 5			potential to be affected by the		
	residents reviewed	for prn pain medication			deficient practice. An audit wa	S	
	administration by a	QMA. (Residents D, E, F, and			completed on all residents tha	t	
	G)				receive PRN pain medications	and	
					physicians were notified if the		
	Findings include:				deficient practice was noted.		
					What measures will be put into	0	
		. Resident D's record was reviewed on 12/16/22			place and what systemic chan	ges	
		agnoses included, but were not			will be made to ensure that the	е	
	limited to, dementia and spinal stenosis.				deficient practice does not rec		
					The QMA scope of practice wa	as	
	1	ders, dated 11/3/22, indicated			reviewed by the IDT team. An		
	Percocet (narcotic pain medication) 5-325				in-service was conducted with	all	
	milligrams (mg), or	ne tablet was to be given every			nurses and QMA's to review the	he	
	12 hours for chronic	c pain and Percocet 5-325 mg,			guidelines. A performance		
	one tabled could be	given every 24 hours as			improvement tool was develop	oed	
	needed (prn) for chi	ronic pain, in addition to the			that audits compliance with		
	every 12 hour pain	medication.			authorization for administration	n	
					was obtained after nurse		
	· ·	tion Administration Record),			assessment of pain.		
		eated a prn Percocet was			How the corrective actions will	l be	
		MA 2 on 12/13/22 at 2:23 p.m.			monitored to ensure the defici	ent	
	1 -	out of 10 and was effective.			practice does not recur;		
		igned out on the Controlled			A performance improvement to	ool	
		/13/22 at 2 p.m. A Licensed			has been initiated that random	nly	
		sed the resident's pain nor			checks three (3) residents to		
	authorized the admi	inistration of the prn Percocet.			ensure that prn medications a	re	
					being supervised by a license		
		g Record, indicated a prn			nurse. This Quality Assurance		
		nistered by QMA 2 on 12/15/22			Audit Toll will be completed by		
	1 -	cet was not documented on the			Director of Nursing/ Designee		
	_	not assessed by a Licensed			Weekly for four (4) weeks; the		
		ness of the Percocet was not			monthly for five (5) months. In		
	· · ·	ensed Nurse had not			event any further concerns are	9	
	authorized the admi	inistration of the prn Percocet.			identified the issue will be		
					immediately corrected and		
		mentation in the Nurses'			additional training will be initia	ted.	
	I -	ssessment/pre-authorization,			Results of the audit will be		
	and the Percocet ha	d been given on 12/12/22,			reviewed at the Quality Assura	ance	
	12/13/22 and 12/15	/22.	1		Meeting at least quarterly.		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155733	B. W.	ING		12/16	/2022
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NDIANA AVE		
COLONIAL NURSING HOME				CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL B. L. S.C. IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION	+	TAG	By what date the systemic		DATE
	2. Resident Els rec	cord was reviewed on 12/16/22			changes will be made: Janua	rv 8	
	at 9:10 a.m. The diagnoses included, but were not limited to, osteoarthritis.				2023		
	·						
	-	er, dated 8/22/22, indicated					
	· ·	e pain medication) 50 mg was to					
		ery six hours as needed for					
	pain (prn).						
	The Controlled Dru	ug Record, indicated the					
		en on 11/23/22 by QMA 2 at 2					
	_	1/24/22 at 3 p.m. and 9 p.m.,					
	11/28/22 at 2 p.m. and 8 p.m., and 11/29/22 at 8 p.m.						
		mentation on the MAR, dated					
		ated the Tramadol had been					
	given. There was no documentation that indicated a Licensed Nurse had authorized the administration of the Tramadol on the MAR or the Controlled Drug Record.						
	There was no documentation in the Nurses'						
	-	assessment of the pain,					
	-	vas given, and the Tramadol					
	had been given on November 23, 24, 28, and 29, 2022.						
	The Controlled Dru	ug Record, indicated the					
		administered by QMA 2 on					
	12/1/22 at 2 p.m. a	nd 8 p.m., 12/6/22 at 2 p.m.,					
	-	n. and 9:30 p.m., 12/13/22 at 3					
	p.m. and 9 p.m. and	d 12/15/22 at 8 p.m.					
	The MAD dated 1	2/2022, had no documentation					
	· ·	peen given and a Licensed					
		I the pain and had given					
		amadol to be given on 12/1/22,					
	12/6/22, 12/9/22, 12/13/22 at 3 p.m., and 12/15/22.						
		d the Tramadol had been given					
	by QMA on 12/13/	22 at 9:04 p.m., there was no					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/16/	ETED	
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 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	
	_	Licensed Nurse and no prior the Licensed Nurse.					
	Tramadol had been 12/12/22 at 8 a.m. 7 medication had bee	ag Record, indicated the administered by QMA 4 on The MAR indicated the n given. There was no or authorization from the					
	Progress Notes an a	mentation in the Nurses' assessment of the pain and was given by the Licensed e dates.					
		ord was reviewed on 12/16/22 iagnoses included, but were not nritis.					
	hydrocodone (narco	r, dated 3/20/22, indicated otic pain medications) 5-325 y six hours for pain could be eded.					
		1/2022, indicated the ot been administered.					
	had administered the 3 p.m. and 8 p.m., 1	ng Record, indicated QMA 2 ne hydrocodone on 11/19/22 at 11/20/22 at 3 p.m. and 8 p.m., and 11/30/22 at 3 p.m.					
	_	ssments and completed by a Licensed Nurse mber dates and times.					
	hydrocodone had b on 12/12/22 at 7:11	2/2022, indicated one een administered by QMA 2 p.m. The pain was rated at a 6 was effective. There was no					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED			
		155733	B. WING		12/16/2022			
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			119 N	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDEDIS DI ANI OE CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR				
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
		indicated a Licensed Nurse						
	-	nd had given pre-authorization						
	for the pain medication to be given.							
	The Controlled Dru	g Record, indicated QMA 2						
		the medication on 12/3/22 at 2						
		2/4/22 at 3 p.m. and 8 p.m.,						
	12/14/22 at 3 and 9							
	There were no asses							
	-	completed by a Licensed Nurse						
	on December 3, 4, a	and 14, 2022.						
	4 Resident G's reco	ord was reviewed on 12/16/22						
		iagnoses included, but were not						
		al vascular disease and stroke.						
	-	r, dated 7/14/22, indicated						
		n medication) 5-325 mg, one						
	table every eight ho	ours as needed for pain.						
	The Controlled Dru	g Record, indicated the Norco						
		2/3/22 at 2 p.m. and 10 p.m. by						
	_	2 p.m. and 10 p.m. by QMA 2.						
		mentation on the MAR, dated						
		was administered on the above						
		o pain assessments and						
	•	-authorization for the Norco to 12/3/22 and 12/4/22.						
	oe administered on	12/3/22 and 12/4/22.						
	The Norco was adm	ninistered by QMA 2 on						
		p.m., 12/4/22 at 2 and 10 p.m.,						
	-	m., and 12/14/22 at 2:35 p.m.						
		2/14/22 was documented on the						
		no Licensed Nurse pain						
	-	e-authorization given from the						
	Nurse.							
	There were no asses	ssments of the pain and						

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

PRINTED: 01/13/2023 FORM APPROVED 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 <u>00</u>		COMPLETED	
		155733	B. WING		12/16/2022	
NAME OF T			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	X	119 N I	NDIANA AVE		
COLONIA	AL NURSING HOM	E	CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	pre-authorization in the Nurses' Progress Notes				
	for the above dates.	•				
	_	v on 12/16/22 at 10:05 a.m., LPN				
		nd been no Licensed Nurse				
		e as needed pain medications				
	for Residents D and	1 E.				
	During an interview	v on 12/16/22 at 10:13 a.m., LPN				
	_	ad been no Licensed Nurse				
		e as needed pain medications				
	for Residents F and	-				
	101 Residents 1 and	i G.				
	During an interview	v on 12/16/22 at 10:43 a.m. the				
	_	g acknowledge the missing				
	-	assessments on the MARs				
	and the lack of asse					
		the Licensed Nurse when				
		ed the pain medications.				
	The "Indiana State	QMA Scope of Practice",				
	indicated PRN med	lications were only to be				
		horization was obtained from				
	the facility's license	ed nurse on duty or on call. If				
	the authorization w	as obtained, the QMA was to				
	ensure the resident'	s record was cosigned by the				
		gave permission by the end of				
	the nurse's shift.	- -				
	This state finding re	elates to Complaint				
	IN00396866.			1		

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