STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155289	A. BUILDING -- B. WING	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL OAKS HEALTH CARE CENTER	4725 S COLONIAL OAKS DR MARION, IN 46953

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/12/24 Facility Number: 000186 Provider Number: 155289 AIM Number: 100266300 At this Emergency Preparedness survey, Colonial Oaks Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 127 and had a census of 94 at the time of this survey. Quality Review completed on 08/15/24	E 0000	/p> ="" p="">	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/12/24 Facility Number: 000186 Provider Number: 155289 AIM Number: 100266300 At this Life Safety Code survey, Colonial Oaks Health Care Center was found not in compliance with Requirements for Participation in	K 0000	/p> ="" p="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christian Livingston	Administrator	08/27/2024

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

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered except for the breakroom closet. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The old assisted living (AL) dining room and the AL service/office hall was surveyed due to the lack of a two hour fire wall between health care and the AL area. The two-hour fire barrier was located at the end of the AL service/office hall that did separate health care from the rest of AL. The facility has a capacity of 127 and had a census of 94 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services was sprinklered, except for the breakroom closet and a detached garage. Quality Review completed on 08/15/24			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health			

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	care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care (HC) from assisted living (AL) was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 40 residents in one smoke compartments. Findings include:	K 0131	K131 Multiple Occupancies – Sections of Health Care Facilities No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The identified fire barrier wall has been corrected by putting fire caulk around the wire to seal the half-inch hole in the wall. The maintenance supervisor/designee will complete observations of the fire wall three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the fire wall is adequately sealed. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to	08/27/2024

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	Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 3:00 p.m., above the drop ceiling of the separation fire barrier at the end of the AL service/office hall had an unsealed half-inch hole in the wall around a wire. Based on interview at the time of observation, the Maintenance agreed the separation fire barrier between HC and AL had an unsealed hole through the wall. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS			

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	Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler			

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	system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 12 non-delayed egress locks did not contain conflicting exit information. This deficient practice could affect 60 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director, Regional Director, and Administrator on 08/12/24 between 1:00 p.m. and 3:00 p.m., the exit doors located by the therapy exit and the exit to assisted living were not provided with delayed egress locks but had signage indicating the doors can be opened in 15 seconds by pushing on the doors. Based on interview at the time of observation, the Maintenance Director agreed the doors were not equipped with delayed egresses but had improper signage. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)	K 0222	K222 Egress Doors No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The identified exit doors had the signage removed that stated the doors could be opened in 15 seconds by pushing on the doors. The Maintenance Supervisor/designee will complete observations weekly to ensure the doors are not mislabeled. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	08/27/2024
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.			

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	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit paths did not have conflicting exit signs. This deficient practice could affect 30 residents that need to use the front exit. Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 12:00 p.m., in the front dining room corridor an "EXIT" sign pointed to the left and to the right. There was no exit door to the right of the sign only to the left. This condition can cause confusion during an emergency evacuation. Based on an interview at the time of observation, the Maintenance Director agreed the sign was pointing two directions and the exit was only to one direction to the left. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)	K 0293	K293 Exit Signage No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The “EXIT” sign no longer points to the right, only to the left – which is where the exit door is located. The exit sign will no longer cause confusion during an emergency evacuation. The Maintenance Supervisor/designee will complete observations of the exit sign three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the exit sign is pointing in the right direction. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	08/27/2024

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K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to ensure 2 of 3 written policies for the protection of residents were the same without conflicting information. Reference LSC Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 11:25 a.m., the facility provided three different fire watch policies, two of the policies stated to contact IDOH via a phone number and not via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The other policy had the correct information. Based on interview during the record review, the Maintenance Director and Administrator agreed not all fire watch policies were the same and contained conflicting information. This finding was reviewed with the Maintenance Director, Environmental Services Director,	K 0346	K346 Fire Alarm System – Out of Service No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The old fire watch policies have been removed from our books, and the correct fire watch policy is the only policy available. The new fire watch policy has the appropriate process for identifying IDOH. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	08/27/2024

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	Regional Director, and Administrator during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of 1 breakroom closets were provided with adequate sprinkler coverage. NFPA 13, 2010 edition, section 8.7.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could up to 20 residents in one smoke compartment.	K 0351	K351 Sprinkler System – Installation No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The closet doors have been removed to allow the spray pattern for the sprinkler head to not be obstructed. The spray pattern will now be able to	08/27/2024

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	Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 12:25 p.m., a newly built closet in the breakroom was not covered by sprinkler protection due to the closet did not contain a sprinkler head and spray pattern for the sprinkler head outside of the closet was obstructed by the doors on the closet. Based on interview at the time of observation, the Maintenance Director agreed there was no sprinkler in the closet and the sprinkler outside of the closet was obstructed by the closet doors. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		cover the closet due to the doors being removed. The Maintenance Supervisor/designee will complete observations weekly to ensure the spray pattern is not obstructed. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			

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	Based on record review and interview, the facility failed to provide 2 of 3 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 11:25 a.m., the facility provided three different fire watch policies, two of the policies stated to contact IDOH via a phone number and not via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The other policy had the correct information. Based on interview during the record review, the Maintenance Director and Administrator agreed not all fire watch policies	K 0354	K354 Sprinkler System – Out of Service No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The old fire watch policies have been removed from our books, and the correct fire watch policy is the only policy available. The new fire watch policy has the appropriate process for identifying IDOH. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	08/27/2024

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	were the same and contained conflicting information. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or			

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(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
	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 25 resident room corridor doors on the southwest 300 hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 317. Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 1:00 p.m., the corridor door to resident room 317 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)	K 0363	K363 Corridor – Doors No residents experienced adverse reactions related to this deficient practice. Two residents had the potential to be affected by this deficient practice. The identified door has been corrected by adjusting the hinge to allow the door to latch correctly. The maintenance supervisor/designee will complete observations of the door three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the door completely latches. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of	08/27/2024

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			monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 1 of 6 smoke barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling	K 0372	K372 Subdivision of Building Spaces – Smoke Barrier Construction No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The identified fire barrier wall has been corrected by putting fire caulk around the wire to seal the half-inch hole in the wall. The maintenance supervisor/designee will complete observations of the fire wall three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the fire wall is adequately sealed.	08/27/2024

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	membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and 50 residents in two smoke compartments. Findings include: Based on with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 3:05 p.m., above the drop ceiling of the S/W300 smoke wall there was a half inch hole around a wire. Based on interview at the time of observation, the Maintenance Director agreed there was an unsealed penetration in the S/W300 smoke barrier. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 #1.) Based on observation and interview, the facility failed to ensure 9 of 40 receptacles within 6 feet from a sink or located in a wet location were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment	K 0511	K511 – Gas and Electric No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. All identified GFCI receptacles are being	09/13/2024

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	to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 residents in the therapy gym. This deficient practice could affect 60 residents on and around the 300-wing. Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 between 12:25 p.m. and 3:00 p.m., the electric receptacles in the 300-wing clean room x2, med-room x2, sink room, clean utility room, and soiled utility room x2 were within six feet of a water source, was protected with a GFCI on the		replaced. All identified receptacles will be replaced by 9/13/2024. The electrical splice in the beauty shop has been repaired. The light is attached appropriately to the ceiling to ensure the electrical splices are maintained in a safe operating condition. Starting the week of 9/16/2024, the maintenance supervisor/designee will complete observations of the GFCI outlets and light in the beauty shop three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the GFCI receptacles are working properly and there are no electrical splices hanging in the beauty shop. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved. The Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at least biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	Braker, but when tested with a GFCI tester the receptacles failed to trip and did not break the electrical circuit. Also in the facilities shower rooms (a wet location), there was a non-GFCI receptacle close to the floor with a water puddle within three feet of a non-GFCI receptacle. Based on interview at the time of observation, the Maintenance Director stated the receptacles were connected to a GFCI braker and the electric receptacles did not properly work when tested. #2.) Based on observation and interview, the facility failed to ensure 1 of 1 electrical splices were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect 20 residents in and around the beauty shop. Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 2:30 p.m., in the beauty shop there was an electrical splice connected to a light hanging from the ceiling and had exposed electrical spliced wiring. Based on an interview at the time of the observation, the Maintenance Director agreed the light hanging from the ceiling had exposed spliced wires. The findings were reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference.			

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K 0711 SS=C Bldg. 01	3.1-19(b) NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview the facility failed to provide a written fire safety plan that correctly addressed a smoke compartment evacuation for 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire LSC 3.3.254 Smoke Partition: A continuous membrane that is designed to form a barrier to limit the transfer of smoke. LSC 3.3.31.2 Smoke Barrier. A continuous	K 0711	K711 Evacuation and Relocation Plan No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The fire safety plan has been updated to exclude “evacuate residents beyond the smoke partition.” The plan now leads to a full evacuation of a smoke compartment. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	08/27/2024

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	membrane, or a membrane with discontinuities created by protected openings, where such membrane is designed and constructed to restrict the movement of smoke. LSC 8.5.2.1 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 11:25 a.m., the provided fire emergency procedures stated, "evacuate residents beyond the smoke partition, full smoke wall, and fire wall. A smoke partition does not separate smoke compartments, restrict the movement of smoke, runs to outside wall to outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier. This condition does not lead to a full evacuation of a smoke compartment. Based on interview during records review, The Maintenance Director confirmed there were four smoke petitions in the building and the fire safety plan had incorrect smoke compartment evacuation procedures. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and			

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	shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service and kitchen exit. Findings include: Based on observations with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 2:38 p.m., smoking on property was evident due to an Assisted Living staff member	K 0741	K741 Smoking Regulations No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. Assisted Living staff member has been in-serviced that we are not a smoking campus and smoking is prohibited on our property. SNF employees and AL employees were in-serviced to ensure this has been corrected.	08/27/2024

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	smoking directly outside the kitchen exit door. Based on records review at 11:00 a.m., the smoking policy stated smoking is not allowed on the facility's property. Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		The Maintenance Supervisor/designee will complete observations of the campus three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the facility remains a smoke-free campus. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

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	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 2:05 p.m., a power-strip in room 320 was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power-strip was in use in a resident care area and did not meet 1363A or 60601-1. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)	K 0920	K920 Electrical Equipment – Power Cords and Extension Cords No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The power strip has been removed from 6ft of a resident care area. The Maintenance Supervisor/designee will complete observations of power strips three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure power strips are not within 6ft of a resident care area. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is	08/27/2024

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			achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is			

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	on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 nonflammable gas cylinders were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 2 residents in room 119. Findings include: Based on observations with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 1:19 p.m., an 'E' type oxygen cylinder was standing upright on the floor in room 119 and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged an 'E' type oxygen cylinder in room	K 0923	K923 Gas Equipment – Cylinder and Container Storage No residents experienced adverse reactions related to this deficient practice. All residents had the potential to be affected by this deficient practice. The “E” type oxygen cylinder was removed from the room. All staff were in-serviced to ensure “E” type oxygen cylinders are always properly stored. The Maintenance Supervisor/designee will complete observations of oxygen cylinders three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure the oxygen cylinders are properly supported. The observations will be documented in a Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is	08/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155289	A. BUILDING 01 B. WING	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL OAKS HEALTH CARE CENTER	4725 S COLONIAL OAKS DR MARION, IN 46953

(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
	119 was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	