| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00454373.<br><br>Complaint IN00454373 - Federal/state deficiencies related to the allegations are cited at F584, F677, F921.<br><br>Unrelated deficiencies are cited.<br><br>Survey date: 3/18/25<br><br>Facility number: 000360<br>Provider number: 155733<br>AIM number: 100290370<br><br>Census Bed Type:<br>SNF/NF: 27<br>Total: 27<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 20<br>Other: 5<br>Total: 27<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review competed on 3/21/25. | F 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective April 4th, 2025, to the Complaint Survey completed on March 18th, 2025. We respectfully request a desk review for paper compliance. | |
| F 0584<br>SS=D<br>Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment<br><br>Based on observation, record review, and interview, the facility failed to ensure residents had a clean and homelike environment related to | F 0584 | F584 [D]<br>Safe/Clean/Comfortable/Homelike Environment<br>It is the practice of this facility that | 04/04/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jennifer Short | Administrator | 04/01/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | soiled bed linens for 2 of 8 residents reviewed for a clean and homelike environment. (Residents B and D)<br><br>Findings include:<br><br>1. During an observation on 3/18/25 at 4:58 a.m., Agency CNA 2 entered Resident B's room to completed incontinence care. A soiled incontinent brief was removed, pericare was completed and a clean brief was applied. When the resident was turned to the side, there was a dried urine ring under the resident's incontinent pad. Agency CNA 2 indicated she had not checked the bottom sheet under the incontinent pad when she provided care earlier in the night.<br><br>Resident B's record was reviewed on 3/18/25 at 10:03 a.m. The diagnoses included, but were not limited to chronic obstructive pulmonary disease.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 1/16/25, indicated a moderately impaired cognitive status, was dependent for toileting, and was always incontinent of bowel and bladder.<br><br>2. During an observation on 3/18/25 at 5:40 a.m., Agency CNA 2 and RN 1 were providing incontinence care to Resident D. The resident had a urinary catheter and had been incontinent of bowel. There was a clean dressing located on her left knee. There was dried blood and other drainage on the sheet under the resident's knee. RN 1 acknowledged the dried drainage on the sheet.<br><br>Resident D's record was reviewed on 3/18/25 at 10:36 a.m. The diagnoses included, but were not | | we ensure that residents receive a safe, clean, comfortable, and homelike environment accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on developed policies and procedures.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Resident B sheets were changed.<br>Resident D sheets were changed<br>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;<br>All residents are subject to be affected by the alleged deficiency<br>Facility audit was conducted that sheets were clean with no negative outcomes<br>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>In-servicing occurred with nursing and c.n.a staff regarding linen being checked and needing to be changed when soiled or dirty<br>A performance improvement tool has been developed to monitor that resident bed linens are clean | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | limited to, stroke.<br><br>A Care Plan, dated 3/11/24, indicated a pressure ulcer was present on the left knee. The interventions indicated a treatment would be completed as ordered by the physician.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated a short and long term memory problem, had a urinary catheter, and was always incontinent of bowel movement. She had one stage three (full thickness tissue loss) pressure ulcer present on admission.<br><br>The Treatment Administration Record, dated 3/2025, indicated the treatment to the left knee had been completed on 3/17/25 on the day shift.<br><br>This citation relates to Complaint IN00454373.<br><br>3.1-19(f) | | IDT reviewed policy on Laundry and Bedding, Soiled<br>How the corrective actions will be monitored to ensure the deficient practice does not recur;<br>A performance improvement tool has been initiated that randomly audits (5) residents to ensure linens are clean. This Quality Assurance Audit Tool will be completed by the Director of Nursing/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.<br>By what date the systemic changes will be made: 04/04/2025 | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br><br>Based on observation, record review and interview, the facility failed to ensure residents who were dependent on staff received incontinence care for 2 of 7 residents reviewed for activities of daily living. (Residents E and F)<br><br>Findings include:<br><br>1. During an observation on 3/18/25 at 5:26 a.m., RN 1 and Agency CNA 2 entered Resident E's room on the C-Hall, to assist with positioning the resident in bed. The incontinence brief was saturated with urine. The incontinence pad under | F 0677 | F677 [D] ADL Care Provided for Dependent Residents<br>It is the practice of this facility that we ensure that residents receive assistance of daily in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on developed policies and procedures.<br>*What corrective action(s) will be accomplished for those residents* | 04/04/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | the resident was soaked with urine and there were circles of dried urine on the sheet under the incontinence pad. The staff repositioned the resident in bed and Agency CNA 2 informed the resident she would be back in a "few minutes". She indicated she had last provided incontinence care at 3:00 a.m.<br><br>During an observation on 3/18/25 at 6:08 a.m., incontinence care had not yet been completed.<br><br>During an observation on 3/18/25 at 7:19 a.m., CNA 3 and LPN 4 entered the room and and completed incontinence care and a linen change. There was a strong urine odor in the room. LPN 4 acknowledged the saturated brief, wet incontinence pad, and the dried urine rings under the pad.<br><br>Resident E's record was reviewed on 3/18/25 at 10:56 a.m. The diagnoses included, but were not limited to, chronic respiratory failure and vascular dementia.<br><br>A Care Plan, dated 3/1/25, indicated there was urinary incontinence. The interventions included, incontinence care would be completed as needed.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 3/4/25, indicated a severely impaired cognitive status, maximum assistance was required for toileting and hygiene, and she was always incontinent of bladder and bowel.<br><br>During an interview on 3/18/25 at 5:35 a.m., Agency CNA 2 indicated she was providing care to the "best of her abilities".<br><br>During an interview on 3/18/25 at 5:46 a.m., Agency CNA 2 indicated she had not completed | | *found to have been affected by the deficient practice;*<br>·Resident E received incontinence care<br>·Resident F brief and bedding was changed<br><br>*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;*<br>All residents are subject to be affected by the alleged deficiency<br>Facility audit was conducted on all dependent residents to ensure ADL care was being provided with no negative outcomes<br><br>*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*<br>·In-servicing occurred with nursing staff to ensuring rounding is occurring minimally every two hours and ADL care is being performed accordingly<br>·A performance improvement tool has been developed to monitor ADL care for dependent residents<br>·IDT reviewed policy for activities of Daily Living (ADLs), Supporting<br><br>*How the corrective actions will be monitored to ensure the deficient practice does not recur;* | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | care on the C-hall yet.<br><br>2. During an observation of Resident F, who resided on the C-Hall, on 3/18/25 at 6:07 a.m. with LPN 4, the incontinence brief, top sheet, and lift sheet were saturated with urine. There were rings of urine on the bottom sheet under the lift sheet. At 6:11 a.m., Agency CNA 5 entered the room and assisted LPN 4 with the resident's incontinence care and linen change.<br><br>Resident F's record was reviewed on 3/18/25 at 11:09 a.m. The diagnoses included, but were not limited to, stroke.<br><br>A Care Plan, dated 4/1/21, indicated there was incontinence of the bladder. The interventions included, incontinence care would be completed as needed.<br><br>A Quarterly MDS assessment, dated 12/28/24, indicated a moderately impaired cognitive status, was dependent for toileting and hygiene, and was always incontinent of bladder and bowel.<br><br>This citation relates to Complaint IN00454373.<br><br>3.1-38(a)(3) | | A performance improvement tool has been initiated that randomly audits (5) residents to ensure ADL care is being provided. This Quality Assurance Audit Tool will be completed by the DON/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.<br>*By what date the systemic changes will be made:* 04/02/2025 | |
| F 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, record review, and interview, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (Agency CNA 1 and Agency CNA 5) when providing care to residents (Resident D and F) who were in Enhanced Barrier Precautions | F 0880 | F880 [E] Infection Prevention & Control<br>It is the practice of this facility to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable | 04/04/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | (EBP) for 2 of 2 residents reviewed for EBP. The facility also failed to ensure hand hygiene was completed by a staff member (Agency CNA 1) after care had been completed on a resident (Resident B) and care initiated on another resident (Resident C) and to ensure a personal care item was used for only 1 resident and was not used for multiple residents (Residents B, C, G, D, and H) by a staff member related to incontinent wipes. (Agency CNA 1)<br><br>Findings include:<br><br>1. During an observation on 3/18/25 at 5:30 a.m., Agency CNA 1 entered Resident D's room to provide care. There was a sign on the outside of the entry door that indicated the resident required EBP during care. Agency CNA 1 applied gloves and was stopped prior to starting care. She indicated she "had no idea" if the resident required PPE due to EBP. The CNA then acknowledged the EBP sign on the outside of the door. She then applied PPE to provide incontinence care.<br><br>Resident D's record was reviewed on 3/18/25 at 10:36 a.m. The diagnoses included, but were not limited to, stroke.<br><br>A Physician's Order, dated 4/19/24, indicated EBP was required due to a feeding tube and pressure wounds.<br><br>A Care Plan, dated 4/20/24, indicated EBP was required. The interventions included the guidelines for EBP would be followed.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated a feeding tube and pressure ulcer were present. | | diseases and infections by ensuring infection control guidelines are in place and implemented.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Agency C.N.A 1 and Agency C.N.A 2 are the same person, and she was slated as a “do not return” to facility immediately. Surveyor was informed during visit at facility<br>Agency C.N.A 5 was inserviced on EBP and handwashing<br>Individual supplies of incontinence wipes were provided to residents B,C,G,D,H<br>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br>All residents who are under EBP isolation have the potential to be affected by the alleged deficient practice.<br>Facility audit was conducted on all dependent residents to ensure EBP and handwashing were being practice properly with no negative outcomes<br>All residents who require the use of incontinence wipes were provided with their own individual supply.<br>What measures will be put into place and what systemic changes | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. During an observation on 3/18/25 at 6:11 a.m., Agency CNA 5 wore gloves and started to provide incontinence care to Resident F and was stopped. Agency CNA 5 indicated she was unsure if the resident required EBP. She then looked at the EBP sign located on the wall outside of the room door and applied the PPE.<br><br>Resident F's record was reviewed on 3/18/25 at 11:09 a.m. The diagnoses included, but were not limited to, stroke.<br><br>A Physician's Order, dated 4/19/24, indicated EBP was to be followed due to a feeding tube.<br><br>A Care Plan, dated 4/20/24, indicated EBP was required due to the feeding tube. The interventions included EBP guidelines would be followed.<br><br>A Quarterly MDS assessment, dated 12/28/24, indicated a feeding tube was present.<br><br>A facility policy for EBP, dated 8/2022 and received as current from the Director of Nursing (DON), indicated EBP was to be used for high contact resident care activities. Gloves and gown would be applied prior to performing the high contact resident care activity.<br><br>3. During an observation on 3/18/25 at 4:58 a.m., Agency CNA 2 completed incontinence care on Resident B. Upon completion of the care, Agency CNA 2 removed her gloves and exited the room without washing her hands. She then started to enter Resident C's room to provide incontinence care and started to don gloves and was stopped. | | will be made to ensure that the deficient practice does not recur.<br>Nursing Department was in-serviced on EBP, Handwashing, and Wipes to be used by only 1 individual<br>1:1 Inservice Conducted with Central Supply to stock each individual room<br>A performance improvement tool has been developed to monitor equipment cleaning protocols.<br>IDT reviewed policy for handwashing and EBP<br><br>How the corrective actions will be monitored to ensure the deficient practice does not recur.<br>A performance improvement tool has been initiated that randomly audits five (5) days to monitor handwashing, EBP, and Individual wipes for each resident. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.<br>By what date the systemic changes will be made:<br>04/02/2025 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | She then went to the sink in the common area and washed her hands.<br><br>A facility policy for handwashing and hand hygiene, dated January 2019 and received from the DON as current, indicated hand hygiene procedures would be followed to help prevent the spread of infections.<br><br>4. During an observations on 3/18/25 from 4:58 a.m. through 5:51 a.m., Agency CNA 2 completed incontinence care on Resident B. Upon leaving Resident B's room, she removed the package of cleansing wipes. She indicated at the time of the observation that she didn't have any other wipes to use. She then entered Resident C's room to provide incontinence care and placed the package of wipes on the over the bed table and provided incontinence care using the wipes.<br><br>Agency CNA 2 then entered Resident G's room and placed the cleansing wipes package on the resident's bed. She then completed incontinence care. After the care, she exited the room with the package of cleansing wipes.<br><br>Agency CNA 2 then entered Resident D's room and used the wipes to complete incontinence care and exited the room with the cleansing wipes package.<br><br>Agency CNA 2 then entered Resident H's room with the cleansing wipes package and used the wipes to complete incontinence care.<br><br>During an interview on 3/18/25 at 6:29 a.m., the Central Supply Clerk indicated there were cleansing wipes in the store room and the nurses' had a key to the storeroom if they were needed. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | An observation of the store room indicated there were cases of cleansing wipes.<br><br>3.1-18(b) | | | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br><br>Based on observation, record review, and interview, the facility failed to ensure the residents' environment was clean and in good repair related to scraped paint, nicks and gouges on the walls, dried feeding on the feeding poles, a oxygen concentrator and on the floor, debris and trash on the floors, a dirty floor mat, and a stool with a cracked vinyl seat for 1 of 2 floors. (First Floor).<br><br>During an environmental tour with the Director of Maintenance/Housekeeping on 3/18/25 from 12:59 through 1:29 p.m., the following was observed:<br><br>a. Room 118 - There were paint scrapes behind the head of the bed. During an interview at the time of the observation, the Director of Maintenance/Housekeeping acknowledged the scrapes and indicated when the residents were discharged or moved rooms, the walls were repaired.<br><br>b. Room 122, bed 2 - There was dried feeding on the feeding pump pole, the oxygen concentrator and on the floor. The Director of Maintenance/Housekeeping indicated the Housekeeper probably had not mopped due to "all the cords."<br><br>c. Room 121, bed 2 - There were nicks on the wall, debris on the floor by the baseboard behind the bed and a plastic medication cup under the bed, | F 0921 | F921 [E]<br>Safe/Functional/Sanitary/ Comfortable Environment<br><br>It is the practice of this facility that the facility is maintained in a sanitary and homelike environment based on developed policies and procedures.<br>*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*<br>Room 118 has been patched and painted<br>Room 122-2 feeding pole and oxygen concentrator has been cleaned<br>Room 121-2 medication cup was removed and has been cleaned<br>Room 121-2 nicks and gouges repaired<br>Room 123-2 nick and gouges repaired<br>Room 123-2 all trash on floor was removed and was cleaned<br>Room 126-2 vinyl seat was removed<br>Room 126-2 feeding pole, floor mat, and room was cleaned<br>Room 125 has been patched | 04/04/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | which was also observed earlier at 6:06 a.m. The Director of Maintenance /Housekeeping indicated the Housekeeper may not have cleaned the room yet.<br><br>d. Room 126 bed 2 - There was dried liquid feeding on the feeding pump pole. There was a dried liquid substance on the floor mat and paper/debris on the floor. There was a rolling stool with a cracked vinyl on the seat in the corner of the room.<br><br>e. Room 125 - there were scrapes and a large gouge on the wall behind the bed.<br><br>f. Room 123, bed 1 - there was paper and a mask on the floor and nicks on the wall behind the head of the bed.<br><br>During an interview on 3/18/25 at 1:15 p.m., Housekeeper 6 indicated the rooms on the first floor had all been cleaned.<br><br>The Housekeeping Completion Form, received as current from the Director of Maintenance/Housekeeping on 3/18/25 at 1:18 p.m., indicated the rooms were to be dusted, swept, and mopped daily including underneath the bed. The walls, furniture, and bedrails were to be cleaned daily.<br><br>This citation relates to Complaint IN00454373.<br><br>3.1-19(e) | | and painted<br><br>*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;*<br>All residents have the potential to be affected by the alleged deficiency.<br>All rooms were audited to ensure all walls were free from gouges and free from a marred appearance, and equipment was in good repair<br><br>*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*<br>1:1 In-servicing occurred with maintenance director regarding needed repairs in the facility.<br>Housekeeping department was inserviced on proper Cleaning and Disinfection<br>A performance improvement tool has been developed to audit ceiling tiles, condition of walls and wall protectors throughout the facility.<br><br>*How the corrective actions will be monitored to ensure the deficient practice does not recur;*<br>A performance improvement tool has been initiated that randomly audits (5) rooms to ensure the items are in good repair and clean. This Quality Assurance Audit Tool | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155733 | A. BUILDING 00<br>B. WING | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| COLONIAL NURSING HOME | 119 N INDIANA AVE<br>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 |
|---|---|---|---|---|
| | | | will be completed by the Maintenance Director/ Designee Weekly three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.<br><br>*By what date the systemic changes will be made:*<br>04/04/2025 | |